SEAMO CabMD Access Request Form Instructions

Please complete all questions on this form as completely and accurately as possible to insure that your request for access is processed in a timely manner.

Incomplete forms will be returned to the originating department.

1. Authorization must come from each individual **physician** where access is being requested (please note that physicians MUST sign the request form personally – no substitute signatures).

2. A completed request form includes the signature of the physician, the external billing agent and the Department Head.

3. **Please forward, via email, the signed copy of the request form to seamo.communication@queensu.ca.**

If you have any questions or concerns regarding the completion of this form, please contact SEAMO at 613-533-6000 ext. 75963.

Please note, if you are uncertain which specialties you are registered in with OHIP, contact OHIP Service Contact Support at: 1-800-262-6524 or **providerregistration.MOH@ontario.ca.

SEAMO CabMD Enterprise Edition Application
Access/Change Request Form — PHYSICIAN

Physician Information **(Full legal name required - please print)**		**Date**
Last Name	First	Middle
Street Address of business		Apartment/Unit #
City	Prov.	Postal Code
Phone	E-mail Address	
OHIP Provider Number	Provider College Number	
Job Title	Department	

Status	Part Time ☐	Full Time ☐	Temp ☐	Contract ☐	Casual ☐
Site	KGH ☐	HDH ☐	PC ☐	Other ☐	Specify:
Account	New Account ☐	Change to Existing Account ☐			
MC EDT Email		Password			
Access Type	Internal KGH Network ☐	External Web Access (citrix) ☐			
Date Access Required:					

External Billing Agent Information **(Full legal name required - please print)**		
☐ **N/A. I will process my own billing.** ☐ **The following external billing agent will perform billing on my behalf:**		
Last Name	First	Middle
Street Address of business		Apartment/Unit #
City	Prov.	Postal Code
Phone	E-mail Address	
Account New Account ☐	Change to Existing Account ☐	

Access Type	Internal KGH Network ☐	External Web Access (citrix) ☐	
Date access required:		Departmental Assistant access form approved	YES ☐ NO ☐

SEAMO CabMD Enterprise Edition Application Access/Change Request Form — PHYSICIAN

Registered Physician Specialty: (check all that apply) *		
☐ Anesthesiology (01)	☐ Cardiology (60)	☐ Cardiovascular and Thoracic Surgery (09)
☐ Clinical Immunology (62)	☐ Dermatology (02)	☐ Emergency Medicine (12)
☐ Endocrinology & Metabolism (15)	☐ Family Practice (00)	☐ Gastroenterology (41)
☐ General Surgery (03)	☐ Genetics (22)	☐ Geriatrics (07)
☐ Haematology (61)	☐ Infectious Disease (46)	☐ Internal Medicine (13)
☐ Medical Oncology (44)	☐ Nephrology (16)	☐ Neurology (18)
☐ Neurosurgery (04)	☐ Obstetrics (20)	☐ Oncology (74)
☐ Ophthalmology (23)	☐ Orthopaedic Surgery (06)	☐ Otolaryngology (24)
☐ Pathology (28)	☐ Paediatrics (26)	☐ Physical Medicine (31)
☐ Plastic Surgery (08)	☐ Psychiatry (19)	☐ Respiratory Diseases (47)
☐ Rheumatology (48)	☐ Thoracic Surgery (64)	☐ Urology (35)
☐ Vascular Surgery (17)	☐ Other: please specify:	

Signatures	
Physician Signature	Date
External Billing Agent Signature (if applicable)	Date
Department Head Signature	Date

To be completed by SEAMO - internal use only:	
Primary Department	Group
Additional Department	Group
Additional Department	Group
Additional Department	Group
Additional Department	Group
Additional Department	Group