HEALTHeNET

Group Management Form

☐ New HEALTHeNET Organization
☐ Modify an existing Organization
What is the change? ____________________
If name change, what is the old name:
____
Note: if name change, will need to re-submit agreements with new name

Organization Information – ALL FIELDS REQUIRED

Legal Entity Name (Name must match Tax ID Attestation Form): ____________________

Organization Type (Hospital, Clinical Practice, etc.): ____________________

Organization Specialty (Pediatrics, Surgery, etc.): ____________________

Is the Organization a Covered Entity (Y/N)? ____________________

Street Address 1: ____________________

Street Address 2: ____________________

City:____________________State:__________Zip Code: __________

County__________Phone Number: __________Fax Number:__________

Tax ID(s):____________________Tax ID Name(s): ____________________

____________________ ____________________
[Attach another page as necessary]

Privacy Officer Contact (Required):

Legal First Name: ____________________ Last Name: ____________________

Job Title: ____________________

Phone number:____________________ Email Address: ____________________

Security Officer Contact (Required):

Legal First Name: ____________________ Last Name: ____________________

Job Title: ____________________

Phone number:____________________ Email Address: ____________________

Authorized Contact (Required):

This is the person(s) who has the authority to add, modify and deactivate user accounts for the practice for HEALTHeNET. Please attach another sheet with the below information if more than 3 Authorized Contacts (AC) are chosen. Every AC needs to complete a HEALTHeNET User Account Form. Every user is required to have their own HEALTHeNET account. Sharing an account with other users is prohibited.

Legal First Name: ______________________________ Last Name: ______________________________

Job Title: ______________________________

Authorized Contact (Optional):

Legal First Name: ______________________________ Last Name: ______________________________

Job Title: ______________________________

Authorized Contact (Optional):

Legal First Name: ______________________________ Last Name: ______________________________

Job Title:______________________________

The undersigned represents and attests that all facts and information are accurate, current, complete, not misleading and that:

- The participant is what he/she represents it to be
- The participant will notify HEALTHeNET of any changes to the information contained on this form within 10 days of such change
- The participant and all agents and employees thereof will at all times accurately represent itself or themselves in all communications using HEALTHeNET services

Authorized Signer: ____

Printed Name: ____

Job Title: ______________________________________ Date: ______________________

The following forms must be completed with each new group submission:

- ☐ HEALTHeNET Data Recipient Agreement
- ☐ HEALTHeNET Data Recipient Terms and Conditions
- ☐ HEALTHeNET Tax Identification Number Attestation Form
- ☐ HEALTHeNET User Account Form

Please email forms and/or questions to servicing@wnyhealthelink.com