HEALTHeNET TAX IDENTIFICATION NUMBER ATTESTATION FORM

This form must be completed in its entirety, whether you are requesting a new group or updating an existing group. All Tax Identification Numbers responsive to the requests in this form must be included each time this form is completed.

Before submitting a new request for access to HEALTHeNET, please verify that your organization has received confirmation from the insurance carriers that you have successfully credentialed with them, or have been added into their system. Failure to credential with the insurance carriers could lead to delays or denial of your HEALTHeNET setup request

Legal Entity Name (Name must match the Group Management Form):
_____

Authorized Representative (Name and Title): _____
Note: The Authorized Representative must verify that the information contained in this form is true, accurate, and up-to-date before signing.

Address: _____

Contact Phone Number: _____

Email Address: _____

I, (Authorized Representative) hereby attest that:

1. (a) Data Recipient's Tax Identification Number is:_____.

(b) Data Recipient is also currently associated with the following Tax Identification Numbers (TINs) and corresponding Tax Identification Names and therefore has the permission to access information in HEALTHeNET as a Business Associate of each entity:

Tax Identification Number	Tax Identification Name
_____	_____
_____	_____
_____	_____
_____	_____

[Attach another page as necessary]

2. Data Recipient is a:
   - ❒ Practice
   - ❒ Facility
   - ❒ Billing Company
   - ❒ Payer
   - ❒ Other _____

3. For each of the TINs listed in section 1(b), Data Recipient has a documented business relationship with the Tax Identification Names listed, which permits access to information relating to the corresponding TIN(s). Data Recipient agrees to provide a copy of the documentation evidencing such relationship (including Business Associate Agreement, if appropriate) to HEALTHeNET upon request.

4. Data Recipient agrees to promptly notify HEALTHeNET in writing of any change in status of this attestation and the information listed above. This attestation replaces any prior attestations and/or confirmations provided to HEALTHeNET.

5. I understand that any falsification, omission, or concealment of material fact may result in sanctions, including revocation of permissions to use HEALTHeNET.

_____ _____

Date **Signature of Authorized Representative**