User Account Form

☐ New HEALTHeNET User
(Every user is required to have their own HEALTHeNET account. Sharing an account with other users is prohibited).

☐ New Authorized Contact (AC)
Choose a 4-digit PIN (**Required**)_____

☐ Modify an Existing User
What is the change?_____Current Login ID : _____

User Information **– ALL FIELDS REQUIRED**

First Name: _____ Last Name: _____

Date of Birth: _____

Legal Organization Name: _____

Organization address: _____

Organization City/State:_____Organization County: _____

Phone Number:_____Ext: _____Fax Number:_____

User's Individual E-mail Address: _____

THIS SECTION IS FOR PHYSICIANS ONLY

Are you a physician? ☐ Yes ☐ No

Physician Name: _____

NPI:_____ NYS License #: _____

Permissions automatically given to all users

Eligibility Inquiry
Referral / Authorization Status Inquiry
Referral Request

Optional permissions to add

☐ Claims Status Inquiry (Note: All Payer users have this permission automatically)
☐ Batch Transactions through UI (Requires functionality in the submitters system to be able to provide transactions in EDI format)

Authorized Contact Approval **– AC SIGNATURE REQUIRED**

I attest that I have verified the identity of the user named above in accordance with HEALTHeNET policies and procedures:

_____ _____
Authorized Contact Signature (Required) **Date**

_____
Authorized Contact Name, Please Print (Required)

Please email forms and questions to: servicing@wnyhealthelink.com

Effective 03/06/2024