HEALTHeNET GROUP FORM

Date: _____

☐ Add Group ☐ Modify Group ☐ Deactivate Group

Office Practice/Hospital Name: _____

Office Address: _____

_____

Office Phone: _____

Tax ID: _____ Organization NPI:_____

Authorized Contact Person(s)

Name: _____ Phone: _____

Email: _____ Pin (Required): _____

Name: _____ Phone: _____

Email: _____ Pin (Required): _____

Name: _____ Phone: _____

Email: _____ Pin (Required): _____

Please include with submission:

- ✓ License Agreement
- ✓ Group Confidentiality Agreement

Please mail completed forms to:
HEALTHeNET, c/o PCI, 703 Washington Street, Buffalo, NY 14203
Please call 1 (877) 895-4724 with any questions.