HEALTHeNET USER FORM

Date: _____

Incident #: _____

☐ Add User ☐ Modify User ☐ Deactivate User

Name of User: _____

Date of Birth: _____

Office Practice Name: _____

Office Address: _____

_____

Office Phone: _____

Work E-mail: _____

Tax ID: _____

Please check the access rights this user will need:

- ☐ Authorization Inquiry (278I)
- ☐ Claim Status (276/277)
- ☐ Eligibility (270/271)
- ☐ Referral Request (278R)
- ☐ Referral Inquiry (278I)
- ☐ HEALTHeLINK Patient Consent

Please check the Region you need access to:

- ☐ Region 1 – Western New York
- ☐ Region 2 – Rochester
- ☐ Region 3 – Syracuse
- ☐ Region 4 – Albany

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