



HEALTHeNET USER FORM

Date: _____

Incident #: _____

<input type="checkbox"/> Add User	<input type="checkbox"/> Modify User	<input type="checkbox"/> 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)
- Provider Inquiry
- Provider Inquiry Summary

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.**