

- New HEALTHeNET Organization
- Modify an existing Organization
What is the change? _____
If name change, what is the old name: _____

For Internal Use Only

Date of Request: _____

Ticket Number: _____

Note: if name change, will need to re-submit agreements with new name

- Deactivate an Organization

Organization Information – ALL FIELDS REQUIRED

Legal Entity Name: _____

Street Address 1: _____

Street Address 2: _____

City: _____ State: _____ Zip Code: _____

County: _____ Phone Number: _____

Tax ID(s): _____ Tax ID Name(s): _____

[Attach another page as necessary]

Authorized Contact (Required):

This is the person(s) who has the authority to add, modify and deactivate user accounts for the practice for HEALTHeNET. Please attach another sheet with the below information if more than 3 Authorized Contacts (AC) are chosen. Every AC needs to complete a HEALTHeNET User Account Form.

Legal First Name: _____ Last Name: _____

Authorized Contact (Optional):

Legal First Name: _____ Last Name: _____

Authorized Contact (Optional):

Legal First Name: _____ Last Name: _____

Please confirm that you are including (if applicable):

- HEALTHeNET Data Recipient Agreement
- HEALTHeNET Data Recipient Terms and Conditions
- HEALTHeNET Tax Identification Number Attestation Form
- HEALTHeNET User Account Form(s)