

**HEALTHeNET TAX IDENTIFICATION NUMBER ATTESTATION FORM**

*This form must be completed in its entirety, whether you are requesting a new group or updating an existing group. All Tax Identification Numbers responsive to the requests in this form must be included each time this form is completed.*

**Legal Entity Name (Please Print or Type):** \_\_\_\_\_ (“Data Recipient”)

**Authorized Representative (Name and Title):** \_\_\_\_\_

*Note: The Authorized Representative must verify that the information contained in this form is true, accurate, and up-to-date before signing.*

**Address:** \_\_\_\_\_

**Contact Phone Number:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

I, (Authorized Representative) hereby attest that:

1. (a) Data Recipient’s Tax Identification Number is:\_\_\_\_\_.

(b) Data Recipient is also currently associated with the following Tax Identification Numbers (TINs) and corresponding Tax Identification Names and therefore has the permission to access information in HEALTHeNET as a Business Associate of each entity:

<u>Tax Identification Number</u>	<u>Tax Identification Name</u>
_____	_____
_____	_____
_____	_____
_____	_____

[Attach another page as necessary]

2. Data Recipient is a:
- Practice
  - Facility
  - Billing Company
  - Payer
  - Other \_\_\_\_\_

3. For each of the TINs listed in section 1(b), Data Recipient has a documented business relationship with the Tax Identification Names listed, which permits access to information relating to the corresponding TIN(s). Data Recipient agrees to provide a copy of the documentation evidencing such relationship (including Business Associate Agreement, if appropriate) to HEALTHeNET upon request.

4. Data Recipient agrees to promptly notify HEALTHeNET in writing of any change in status of this attestation and the information listed above. This attestation replaces any prior attestations and/or confirmations provided to HEALTHeNET.

5. I understand that any falsification, omission, or concealment of material fact may result in sanctions, including revocation of permissions to use HEALTHeNET.

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Authorized Representative**