Group Management Form

☐ New HEALTHeNET Organization

☐ Modify an existing Organization

What is the change? _____

If name change, what is the old name:

_____

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

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: _____

The undersigned represents and attests that all facts and information are accurate, current, complete, not misleading and that:

- The participant is what he/she represents it to be
- The participant will notify HEALTHeNET of any changes to the information contained on this form within 10 days of such change
- The participant and all agents and employees there of will at all times accurately represent itself or themselves in all communications using HEALTHeNET services

Authorized Signer: _____

Printed Name: _____

Title: _____ Date: _____

The following forms must be completed with each new group submission:

☐ HEALTHeNET Data Recipient Agreement

☐ HEALTHeNET Data Recipient Terms and Conditions

☐ HEALTHeNET Tax Identification Number Attestation Form

☐ HEALTHeNET User Account Form

Please email forms and/or questions to training@wnyhealthelink.com

Effective 04/01/2020