User Account Form

☐ New HEALTHeNET User

☐ New Authorized Contact (AC)

Choose a 4-digit PIN (**Required**)_____

☐ Modify an Existing User

What is the change?_____ Current Login ID : _____

User Information **– ALL FIELDS REQUIRED**

First Name: _____ Last Name: _____

Date of Birth: _____

Legal Organization Name: _____

Organization address: _____

Organization City/State:_____ Organization County: _____

Phone Number:_____ Ext: _____ Fax Number:_____

User's Individual E-mail Address: _____

Employee ID (HealthNow only): _____

THIS SECTION IS FOR PHYSICIANS ONLY

Are you a physician? ☐ Yes ☐ No

Physician Name: _____

NPI:_____ NYS License #: _____

Organization Specialty (if applicable)

☐ Ground/Air Ambulance
☐ Durable Medical Equipment (DME)
☐ Laboratory
☐ Dental

Permissions automatically given to all users

Eligibility Inquiry
Provider Inquiry
Referral Request
Referral / Authorization Status Inquiry

Optional permissions to add

☐ Claims Status Inquiry (Note: All Payer users have this permission automatically)
☐ Batch Transactions through UI (Requires functionality in the submitters system to be able to provide transactions in EDI format)
☐ HealthNow Authorized Contact (BlueCross BlueShield of Western New York / BlueShield of Northeastern New York) – Access to Risk Manager and Reports on Provider Website

Authorized Contact Approval **– AC SIGNATURE REQUIRED**

I attest that I have verified the identity of the user named above in accordance with HEALTHeNET policies and procedures:

_____ _____

Authorized Contact Signature (Required) **Date**

_____

Authorized Contact Name, Please Print (Required)