



# ON-LINE REGISTRATION FORM

PLEASE TYPE or PRINT CLEARLY

(\* denotes a required field)

## Contact Information

\*Provider Name: \_\_\_\_\_

\*Group Name: \_\_\_\_\_  
(If applicable)

\*Address: \_\_\_\_\_  
Number/Street City State Zip (+ 4)

\*Contact Name: \_\_\_\_\_ \*Telephone: ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Facsimile: ( ) \_\_\_\_\_

QUEST ID#: \_\_\_\_\_ \*Fed Tax ID#: \_\_\_\_\_

### List All Persons in Your Office Who Will Access AlohaCare On-Line

(Please use additional copies of this form if you will have more than 5 authorized users.)

	*User Name (Last Name, First Name)	*Title/Position	Phone Number	Claim Access *(Y/N)	Referral Access *(Y/N)
1			( )		
2			( )		
3			( )		
4			( )		
5			( )		

I authorize the above users to access AlohaCare On-Line for my/our patients. I agree that the users listed above will abide by AlohaCare's Confidentiality Policy, Federal and State regulations applicable to patient privacy, and the confidentiality requirements stated in the Provider Manual. Any violations of these policies, regulations, or requirement may result in loss of privileges, termination of rights, and/or fines. The violations may also be reported to the proper Federal and State regulatory agencies.

\*Authorized Signature: \_\_\_\_\_ \*Date: \_\_\_\_\_

\*Print Name: \_\_\_\_\_ \*Title/Position: \_\_\_\_\_

**Please Fax Completed Form to AlohaCare**

**Fax Attention to: Provider Relations Department**

**Oahu: 973-0204 Neighbor Islands/Mainland: 1-866-973-0204**