AlohaCare
For a healthy Hawaii.

AC ONLINE REGISTRATION FORM

PLEASE TYPE or PRINT CLEARLY

(* denotes 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#: _____ *Federal Tax ID#: _____

List all persons in your office who will access AC Online

(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 AC Online 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: _____

Fax completed form to AlohaCare

Attention: Provider Relations Department

Fax: (808) 973-0811