KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States

PART II - Kaiser Permanente HealthConnect AffiliateLink Website User Enrollment Form

An enrollment form must be completed by **each** individual user to establish access to the new web site. Please make additional copies of this form as needed. **Print legibly, complete all fields,** and **fax** the completed form to **855-414-2624.**

Section A. Participating Provider/Group – Group Administrator Information

1. Provider/Group/Practice Name: _____

   Group Administrator Name (Last, First, MI): _____

2. Tax ID: _____

3. Office Address: _____

   _____

4. Work Phone: _____

5. Work Email: _____

Section B. Individual User Information

1. Name (Last, First, MI): _____

2. Last four (4) digits of your SSN: _____ (Used for identification purposes only.)

3. Office Address:

   _____

   _____

4. Work Phone: _____

5. Work Email: _____

6. Which of the following best describes your job, position, or role? (Circle one)

Physician	Practitioner	Nurse	Physician Assistant	Front Office Staff
Medical Assistant	Surgical Coordinator	Office Manager	Practice Manager	Billing Staff
Vendor	Hospitalist	Other_____		

7. NPI (if applicable): _____

8. License/Certification (if applicable): _____

9. Have you ever been given a NUID (user ID for Kaiser Permanente Health Connect or Provider Online tools)?

   YES □ NO □ If yes, please provide your NUID: _____

FOR PROVIDER EXPERIENCE USE ONLY – PLEASE DO NOT WRITE IN THE BOX BELOW

Access Level Required

□ Clinical Support □ Hospitalist □ Support Staff □ KP ADMIN

Identifying Spread Sheet_____