CENTRAL HEALTH

Authorization Agreement for Web Use

I (we) hereby request authorization from Central Health MSO, Inc. to use the Web Base system for the following IPAs:

___ Advantage Care IPA "AIPA"

In order to retrieve access to your account, you will be given the following instructions:

1. CCA HelpDesk will send you a confirmation e-mail. Please confirm that your information has been verified by responding to the email.
2. Once you have responded to the confirmation e-mail, you will be given a secondary e-mail with a temporary password and a link to CCA. We will not send your username for security purposes in this e-mail

This authorization is to remain in full force and effect until Provider received written or verbal notification from Central Health MSO, Inc. of its termination in such time and in such manner as to afford Provider opportunity to act on it.

Primary Provider Name: _____

Tax ID#: _____

*Primary Telephone #: _____

* Primary E-mail Address: _____

* A Valid E-mail and Telephone are required to use web application

Please supply Central Health MSO with a User Name:

Username/Login: _____

The username cannot contain any spaces or special characters

Please supply a list of additional Providers associated with your Office or Billing Office with each Provider signing next to their name:

Provider Name: _____ Signature: _____
Provider Name: _____ Signature: _____
Provider Name: _____ Signature: _____
Provider Name: _____ Signature: _____
Provider Name: _____ Signature: _____

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I (we) hereby agree to employ reasonable security procedures to ensure technical and physical safeguards to protect the privacy, security, integrity and confidentiality of data electronically exchanged.

I (we) hereby agree that the information provided is accurate, reliable, and complete with appropriate ICD-9 and CPT coding.

I (we) hereby agree to adhere to the HIPAA policies and procedures regarding patient privacy and the security of patient information, as well as all applicable laws regarding the privacy and security of the patient information.

I have read the above agreement and agree to comply with its terms as a condition of access to the Web.

Please supply the following information for reference:

**Contact Name: _____

**Contact Phone: _____

**Contact Fax: _____

** All contact information will be verified to use CCA.
All information for verification and password or password resetting will be sent to contact.

Fax Application to (626) 388-2356

or mail to:
Central Health MSO, Inc.
1540 Bridgegate Drive
Diamond Bar, CA 91765
Attn: CCA HelpDesk / Web Application