AlohaCare
For a healthy Hawaii.

AC Online Registration Form

Please Type or Print Clearly

Contact Information

Provider Name: _____

Group Name: _____

Address: _____

Contact Name: _____ Phone: _____

Email: _____ Fax: _____

Federal Tax ID #: _____

Designated Administrator

The designated administrator will add and delete users for their providers AC Online account.

Last Name, First Name	Title/Position	Phone	Claim Access (Y/N)	Referral Access (Y/N)

Employees

List all persons in your office who will access AC Online
(Please use additional copies of this form if you will have more authorized users.)

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

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 (808) 973-0811
AlohaCare | Attention: Provider Relations Department