



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:

- Physicians' Healthways IPA "PHW"
 - Advantage Care IPA "AIPA"
 - Associated Physicians IPA East San Gabriel Valley "APSG"
- Only Check the IPA(s) that you are contracted with.**

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.

Primary Provider / Office Name: _____

*Telephone #: _____

*E-mail Address: _____

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

Please supply Central Health MSO with a User Name:

User/Login Name: _____

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: _____

Provider Name: _____ Signature: _____

Provider Name: _____ Signature: _____

Once the information from your office has been verified, we will E-mail you a unique password and link to the web site. We will not send the user name 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 Signature: _____ Date: _____

Please supply the following requested information:

**Contact Name: _____

**Contact Phone: _____

**Contact Fax: _____

**Contact E-mail: _____

** All E-mail Addresses and Telephone Numbers will be verified to use web application. All information for verification and password or password re-setting 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: IS Dept / Web Application

Internal Use Only

All Providers Verified by: _____ Date: _____

Provider E-Mail Address Verified by: _____ Date: _____

Provider Phone # Verified by: _____ Date: _____

Contact E-Mail Address Verified by: _____ Date: _____

Contact Phone # Verified by: _____ Date: _____

E-Mail Password and Link by: _____ Date: _____

Central Health MSO, Inc. – Information Systems Department
(626) 388-2300 Ext. 1195