**Health Commerce System Account Creation**

**Organization Information:**

|  |  |
| --- | --- |
| Organization type:  | Health Home or CMA?Adults, Children or Both? |
| **To avoid potential errors that can occur from misreading handwritten documents this form should be typed.** |
| Organization name:  |  |
| MMIS Provider ID: (required) |  |
|  |  |
| 1. **Health Commerce System Director Account Application**
 |
| 1. Full first name (DO NOT use nicknames), full middle name (not just the initial), and full last name. (For example: Elizabeth Ann Doe)
 |  |
| 1. Month and day of birth
 |  |
| 1. NYSDOH Health Commerce System (HCS) ID (if one exists)
 |  |
| 1. Job title (needed for Director requests)
 |  |
| 1. Work address
 |  |
| 1. Office telephone number
 |  |
| 1. Office fax number
 |  |
| 1. E-mail address
 |  |
| 1. Existing Director being replaced (if applicable)
 |  |
| * 1. If the Coordinator is replacing someone, does the Coordinator being replaced need to retain an account as a user for the organization?
 |  |

|  |  |
| --- | --- |
| Director’s Name  |  |
| Director’s Title |  |
| Date |  |

1. **Health Commerce System Coordinator 1 Account Application**

|  |  |
| --- | --- |
| 1. Full first name (DO NOT use nicknames), full middle name (not just the initial), and full last name. (For example: Elizabeth Ann Doe)
 |  |
| 1. Month and day of birth
 |  |
| 1. NYSDOH Health Commerce System (HCS) ID (if one exists)
 |  |
| 1. Work address
 |  |
| 1. Director's name (needed for Coordinator requests)
 |  |
| 1. Office telephone number
 |  |
| 1. Office fax number
 |  |
| 1. E-mail address
 |  |
| 1. Existing Coordinator being replaced (if applicable)
 |  |
| * 1. If the Coordinator is replacing someone, does the Coordinator being replaced need to retain an account as a user for the organization?
 |  |

1. **Health Commerce System Coordinator 2 Account Application**

|  |  |
| --- | --- |
| 1. Full first name (DO NOT use nicknames), full middle name (not just the initial), and full last name. (For example: Elizabeth Ann Doe)
 |  |
| 1. Month and day of birth
 |  |
| 1. NYSDOH Health Commerce System (HCS) ID (if one exists)
 |  |
| 1. Work address
 |  |
| 1. Director's name (needed for Coordinator requests)
 |  |
| 1. Office telephone number
 |  |
| 1. Office fax number
 |  |
| 1. E-mail address
 |  |
| 1. Existing Coordinator being replaced (if applicable)
 |  |
| * 1. If the Coordinator is replacing someone, does the Coordinator being replaced need to retain an account as a user for the organization?
 |  |

**Directions for Submitting the completed form**

Click on the following link:

<https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action>

Choose “Health Commerce Accounts for Health Homes” from the drop down list.

Click on“Browse” to attach this completed document.

Once attached, click submit.