**Health Home Care Management Agency**

**Health Commerce System Account Request**

1. **Director Account Health Commerce System Request**

|  |  |
| --- | --- |
| 1. Organization type | Health Home CMA |
| 1. Legal Organization name |  |
| 1. HCS Organization Identification Number |  |
| 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 (MM/DD) |  |
| 1. NYSDOH Health Commerce System (HCS) ID (if one exists) |  |
| 1. Job title |  |
| 1. Work address |  |
| 1. Office telephone number |  |
| 1. Office fax number |  |
| 1. E-mail address |  |

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

***Note: This form does not need to be signed by the HCS Director or notarized***

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

|  |  |
| --- | --- |
| 1. Organization type | Health Home CMA |
| 1. Legal Organization name |  |
| 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 (MM/DD) |  |
| 1. NYSDOH Health Commerce System (HCS) ID (if one exists) |  |
| 1. Work address |  |
| 1. Office telephone number |  |
| 1. Office fax number |  |
| 1. E-mail address |  |

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

|  |  |
| --- | --- |
| 1. Organization type | Health Home CMA |
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| 1. Full first name (DO NOT use Ito expeditnicknames), 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. Office telephone number |  |
| 1. Office fax number |  |
| 1. E-mail address |  |