**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 |
| 1. Legal Organization name
 |  |
| 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
 |  |