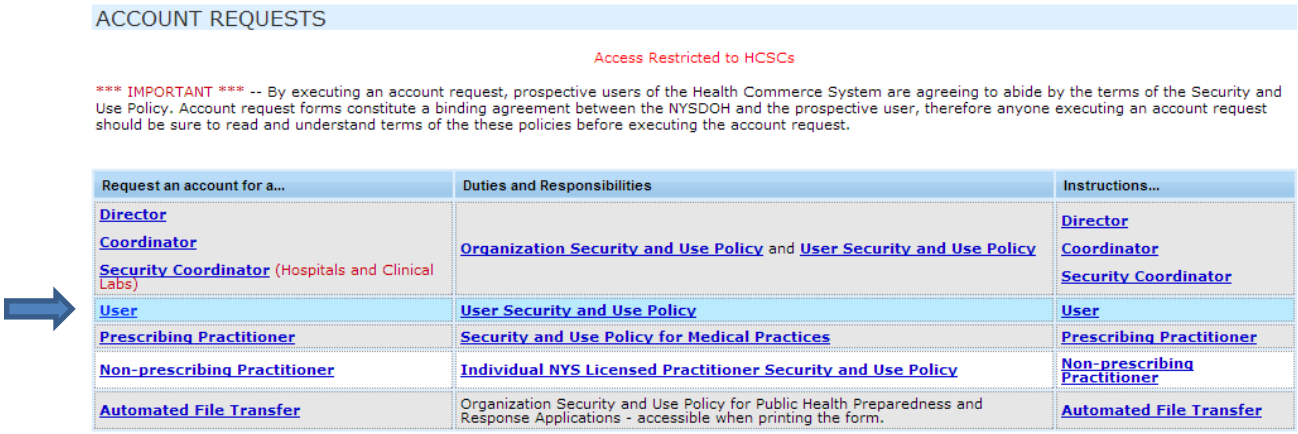
Obtaining a Health Commerce System (HCS) Account for *UNLICENSED* Professionals
Residents, Limited Permit Physicians, Medical Assistants, Pharmacy Interns, and Administrative Staff

Note: To be completed by HCS Director or HCS Coordinator (e.g., Facility Administrator or Prescribing Practitioner)

1) Login to the Health Commerce System (https://commerce.health.state.ny.us).
2) Click on "Coord Account Tools – HCS" under My Applications.

3) Under Account Requests, click "User".



ACCOUNT REQUESTS

Access Restricted to HCSCs

*** IMPORTANT *** -- By executing an account request, prospective users of the Health Commerce System are agreeing to abide by the terms of the Security and Use Policy. Account request forms constitute a binding agreement between the NYSDOH and the prospective user, therefore anyone executing an account request should be sure to read and understand terms of the these policies before executing the account request.

Request an account for a...	Duties and Responsibilities	Instructions...
Director Coordinator Security Coordinator (Hospitals and Clinical Labs)	Organization Security and Use Policy and User Security and Use Policy	Director Coordinator Security Coordinator
User	User Security and Use Policy	User
Prescribing Practitioner	Security and Use Policy for Medical Practices	Prescribing Practitioner
Non-prescribing Practitioner	Individual NYS Licensed Practitioner Security and Use Policy	Non-prescribing Practitioner
Automated File Transfer	Organization Security and Use Policy for Public Health Preparedness and Response Applications - accessible when printing the form.	Automated File Transfer

4) Gather the information required by Steps 1-9 under “Information Needed to Complete the Form”.

Contact Info: **CAMU**
Commerce Accounts Management Unit
Revised: July 2011

User Account Request Form

Document 2

Information Needed to Complete the Form

Please have the following **User** information BEFORE continuing:

1. Organization
2. Full first name (DO NOT use nicknames), full middle name (not just the initial), and full last name. (For example: Elizabeth Ann Doe).
3. Month and day of birth
4. NYSDOH Health Commerce System (HCS) ID (if one exists)
5. Job title
6. Work address
7. Office telephone number
8. Office fax number
9. E-mail address

Continue

5) Click Continue when ready.
6) Fill in the user’s information, and click “Continue”.

New York State Department of Health
HPN Electronic Document 2 - Individual Account Request Form
Data Entry for Schedule 2.A

SEARCH Screen

See **Electronic Document 2 Instructions**

Be sure that you are able to print from your PC before completing this document. This is a printable only Adobe Acrobat PDF document. If you don't have Adobe Acrobat Reader Version 5.0 or later, please download the Reader software (free) from the **Adobe Acrobat web site** link

This screen searches against our database to check for names that match your request. If a match IS NOT found, a partially filled form will appear. If a match IS found, a list of names will display for you to check and see if your employee already appears on the HPN.

*(NOTE: ALL FIELDS MARKED WITH AN ASTERISK (*) ARE REQUIRED)*

Participant Organization Type: **Z Test Pharmacy 1/Pharmacy**

User's Information:

First name * : John
Middle name: Smith
Last name * : Doe
NYSDOH Health Commerce ID (if known) :

CONTINUE

START OVER

HPN Home Page

7) Fill in all of the required fields, and click “Continue”.

New York State Department of Health
HPN Electronic Document 2 - Individual Account Request Form
Data Entry for Schedule 2.A

DATA ENTRY Screen

INSTRUCTIONS: Enter data and select from drop down lists
*(NOTE: ALL FIELDS MARKED WITH AN ASTERISK (*) ARE REQUIRED)*

User's First Name * : John Middle: Smith Last * : Doe

User's title:

Participant Organization Type: **Z Test Pharmacy 1/Pharmacy**

Mailing Address * : Corning Tower 2345

City * : Albany State * : NY Zip * : 12237

Telephone Area * : 518 123 - 4567 Ext.:

Fax Area * : 518 123 - 7654

Enter the User's e-mail address in the following format: userid@host.domain

User's e-mail * : John.Doe@example.com

Month/Day of Birth * : 01 / 01

For documentation purposes: If the user requires access to an HCS application, please select from the limited list of applications below. If the application you need is not listed or the user needs access for another reason, you may skip this section.

Adult Cystic Fibrosis Assistance Program
Authorized Training Agencies (ATA)
Bureau of Narcotic Enforcement Official NYS Prescription System
Cancer Registry
Cardiac Services Program Access Initiative
Certified Home Health Agency Cost Report

Coordinator Name: **Jane Smith**
Coordinator Id: **jxs01**
Coordinator Phone: **518-123-4567** Ext.:

'CONTINUE' -- when all data is entered, 'START OVER' -- go to first page for different account

CONTINUE START OVER

8) If you made an error filling out the information, you may correct the data and click “MODIFY DATA”. Otherwise, click “CREATE DOC2”.

New York State Department of Health
HPN Electronic Document 2 - Individual Account Request Form
Data Entry for Schedule 2.A

MODIFY DATA or CREATE DOC2 Screen

INSTRUCTIONS: To make changes, enter data and then click MODIFY DATA. When all the data is correct, click CREATE DOC2.
*(NOTE: ALL FIELDS MARKED WITH AN ASTERISK (*) ARE REQUIRED)*

User's First Name * : John Middle: Smith Last * : Doe

User's title:

Participant Organization Type: **Z Test Pharmacy 1/Pharmacy**

Mailing Address * : Corning Tower 2345

City * : Albany State * : NY Zip * : 12237

Telephone Area * : 518 123 - 4567 Ext.:

Fax Area * : 518 123 - 7654

Enter the User's e-mail address in the following format: userid@host.domain

User's e-mail * : john.doe@example.com

Month/Day of Birth * : 01 / 01

For documentation purposes: If the user requires access to an HCS application, please select from the limited list of applications below. If the application you need is not listed or the user needs access for another reason, you may skip this section.

Adult Cystic Fibrosis Assistance Program
Authorized Training Agencies (ATA)
Bureau of Narcotic Enforcement Official NYS Prescription System
Cancer Registry
Cardiac Services Program Access Initiative
Certified Home Health Agency Cost Report

Coordinator Name: **Jane Smith**

Coordinator Id: **jxs01**

Coordinator Phone: **518-123-4567** Ext.:

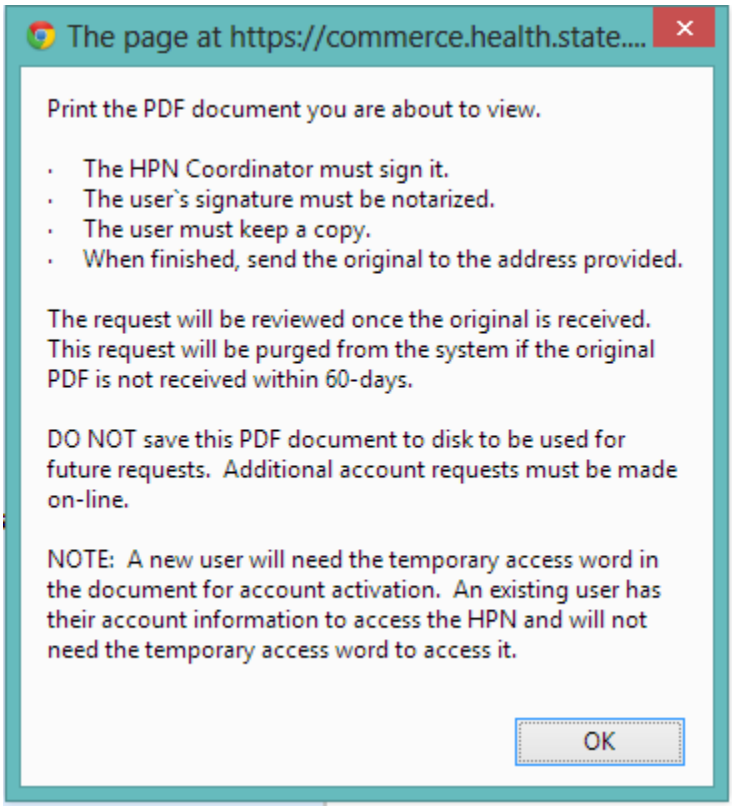
'MODIFY DATA' -- to modify the data entered, 'START OVER' -- go to first page for different account.
'CREATE DOC2' -- to print the PDF document.

MODIFY DATA START OVER

CREATE DOC2

You must click CREATE DOC2 to complete the account request.

9) Read the instructions in the on-screen prompt, and click “OK”.



After clicking “OK”, the HCS (HPN) document will load.

The HCS (HPN) document will be rejected by NYSDOH/CAMU if it does not contain the following:

- User’s signature (#8 - Account Requestor Signature)
- Coordinator’s signature (#7 – HPN Coordinator Signature)
- User’s signature is notarized
- Notary can’t be an interested party
- Notary section must be complete (city, state where taken)

Note: Ensure that you retain a copy of the HCS (HPN) form. You will need this to activate your account.

HPN Document 2 – Schedule 2.A
HPN Individual Account Request Form

Account Requestor completes lines 1-5

I have read in its entirety and understand the HPN Individual User Security and Use Policy and Application (aka Document 2, including Schedule 1.A). I agree to the terms and conditions for HPN access and use described in Document 2 including Schedule 1.A. I fully understand that non-compliance can result in immediate suspension of network access, investigation, and/or, referral for appropriate legal action. I understand that logging and monitoring of keystrokes and other monitoring activities will occur. I will not share my account's access information with anyone else. This is my individual account. **I understand that I am responsible for any activity attributable to the use of this account.**

1. Name :John Smith Doe
2. Name of Organization: Z Test Pharmacy 1
3. Address: Corning Tower 2345

   City: Albany ST: NY Zip: 12237

4. Telephone: 518-123-4567 Extn: ----- Email: john.doe@example.com
5. HPN User ID **(if one exists)** ------- **OR**

   Month/Day of Birth: 01/01
   (Used to ensure a unique account)

   Temporary Access Word: [redacted]

Required to activate your account

HPN Coordinator completes lines 6 – 7; Account Requestor signs line 8 in presence of Notary

I am a valid HPN coordinator for this organization. I have the authority to bind the Participant Organization in matters relating to the HPN. I have read, understand and affirm that the organization is bound by the terms and conditions of the Participant Organization and Use Policy (aka Document 1) and the HPN Individual User Security and Use Policy and Application (aka Document 2). I affirm and agree on behalf of the organization that a) the subject user is affiliated with our organization, has valid need for access to the HPN and that due diligence has been exercised in ascertaining this determination; b) the Organization is bound to enforce the terms and conditions of this agreement on behalf of this user; and c) the Organization will be held responsible for actions of this user in regards to their compliance with the HPN policies as stated.

6. HPN Coordinator Name: HPN ID:
7. **HPN Coordinator Signature:** _____
8. **Account Requestor Signature:** _____

Notary completes lines 9 – 10

9.) ss.: On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared

John Smith Doe, _____
personally known to me or proved to me on the basis of satisfactory evidence to be
the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, that by his/her signature on the instrument, the individual executed the instrument, and that such individual made such appearance before the undersigned in _____.
(insert the city or political subdivision and the state the acknowledgement was taken)

10. **Notary signature** and stamp here: _____

[redacted]

Please keep a copy for yourself but send this page to:
NYSDOH, CAMU Supervisors, 800 North Pearl Street, Room 214
Albany, NY 12204

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10) Within two weeks after mailing your notarized HCS (HPN) document to NYSDOH/CAMU, you will receive a letter in the mail with your PIN number and instructions on how to activate your account.

Note: If you do not receive a letter within two weeks, please contact the Commerce Account Management Unit at 1-866-529-1890 (Option 2).

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

05/08/2013

[redacted]

Dear [redacted],

Your Health Commerce System account request form has been processed. You can now activate your account on-line. To do this you must have your Personal Identification Number (PIN) (see below) and the temporary acces word on the copy of your bar-coded notarized account request form. Detailed instructions are enclosed. Please keep your PIN in a confidential place. You will need to reference it whenever you need to discuss your account with the Commerce Accounts Management Unit (CAMU)

You have 20 days from the date of this letter to activate your account on-line. If the 20 days has elapsed or you have 5 failed attempts, the account will be locked and you must call CAMU at 1-866-529-1890 option 1 to activate your account.

For problems related your on-line account activation or your password, please contact CAMU of NYSDOH at NYSDOH-Commerce-Help@health.state.ny.us or **1-866-529-1890 option 1.** You must also notify CAMU in case of loss, theft, or compromise of your PIN, or if a change in your duties or employment status affects your legitimate access privilege to the Commerce site.

Please contact the pertinent NYSDOH program area if you are experiencing difficulties with your on-line application.

Thank you in advance for your attention to these instructions.

Sincerely,
Commerce Accounts Management Unit

Enc.

Personal Identification Number

[redacted]

THIS PIN IS CRITICAL TO COMMERCE ACCESS

Fold here

- This number is ESSENTIAL when contacting CAMU
- Keep this in a confidential place
- Never reveal your PIN to anyone. Do not write it down.
- If the security of your PIN becomes compromised -lost, stolen, used by someone else, notify CAMU immediately and you will be issued a new PIN.

CAMU staff can be reached at **1-866-529-1890 option 1** or NYSDOH-Commerce-Help@health.state.ny.us

HEALTH.NY.GOV
facebook.com/NYSDOH

11) Once you have your PIN Number and Temporary Access Word you may activate your account. Go to the website: https://hcsteamwork1.health.state.ny.us/pub/cgi-bin/applinks/pubforms/olaa/activate and enter in your information. You will be prompted to change your password at this time. Please use the "Forgotten Password" function to allow you

to reset your password at any time in case you forget your password in the future. **Please login to your HCS account every 90 days to keep your account active.**

Steps to activate your Health Commerce System (HCS) account on-line

To activate your account on-line you must have your personal identification number (PIN) letter and temporary access word. found on your copy of the bar-coded notarized account request form. You have 20 days from the date of the PIN letter to complete this process. If the 20 days has elapsed or you have 5 failed attempts, the account will be locked and you must call 1-866-529-1890 option 1 to activate your account.

Activate your HCS account:

- Enter the following address in your browser's address bar to start the "On-Line Account Activation". https://hcsteamwork1.health.state.ny.us/pub/cgi-bin/applinks/pubforms/olaa/activate
- Enter your last name in the "last name" field.
- Enter your PIN in the "PIN number" field (located on the PIN letter you received with these instructions).
- Enter your temporary access word in the "temporary access word" field (located on the bar-coded notarized form).
- Click **CONTINUE.**

Congratulations! You have activated your User ID:

- Make note of your User ID on top in blue (you will need it for all future HCS access)

Change your password (temporary access word):

- Enter your User ID in the "User ID" field.
- Enter your temporary access word in the "Password" field.
- Click **Sign In.**
- Enter your temporary access word in the "Password" field
- Click **Next.**
- Enter a new password in the "New Password" field.
- Enter the new password in the "Confirm Password" field.
- Click **Change Password.**

Activate your Self-Service Forgotten Password Feature:

- Enter six of the 27 questions (you will be required to answer three when using the feature)
- Click **Save.**

Your account is active!

For all future HCS access, go to this website - **https://commerce.health.state.ny.us**
(remember to bookmark it)

For HCS training (Coordinator or Introduction to HCS), please email the Commerce Trainers at hcsoutreach@health.state.ny.us.

For both security and quality of service, logs and audit trails are kept of all HCS accesses. Refer to your SAUP for details. Violation of the SAUP (e.g. sharing your confidential account information) will result in the suspension of your account privileges until executives at your organization take required remedial action. Repeat offenses may result in the permanent removal of the account.