Arizona Medical Information Exchange
Viewer Account Management Form

AHCCCS

Operations Support 602-708-2681 Fax 602-417-6999

Select one of the following**:

☐ New ☐ Update User ☐ Inactivate User ☐ Reactivate User

User Detail		
Last Name*	***First Name****	***Middle Initial***
Suffix (Jr., Sr. etc.)	***Credentials (ex. RN, MD, DO, NP)***	***Primary Specialty***

Affiliation Detail		
Primary Affiliation/Organization*	***Title***	***Valid Picture ID Checked?*** Yes_____ No_____
Location Address 1	***Address 2***	
City	***State***	***Zip code***
Primary Phone*	***Secondary Phone***	***Fax***
Email Address*	***AHCCCS Provider ID***	***Scheduled Training Date****

I understand that as a condition of being registered as a user of the AHCCCS HIeHR Utility, I am bound by the terms of the Participation Agreement, HIeHR Privacy and Security policies and standards and all applicable laws and regulations governing HIPAA, Personally Identifiable Information (PII) and Protected Health Information (PHI). If any of the above information should change, I will immediately inform the Project Director.

User Signature* _____ ***Date**** _____

Activation or Inactivation Date/Approval		
Requested Effective Date*	***Authorized Signature (Participant Representative)****	***Signature Date****

For Internal AHCCCS Use only		
Date Received by AHCCCS	***Reviewed By***	***Review Date***
Comments		
User Name	***Temporary Password***	
Effective Date	***System Administrator***	***Signature Date****

* Unless otherwise noted, the System Administrator Signature Date is the Date the change was made in the system.

** Required Fields