



Elysium User Account Form

Check One: NEW ACCOUNT / ACCOUNT CHANGE / ACCOUNT TERMINATION

Select Authentication: EXISTING CHS FOB – ADD TO VPN ECMCC AFFILIATE

Part I: User Information

Date:

User First Name: _____ Middle Initial: _____ User Last Name: _____

D.O.B. _____ HealthNet User Account (Y/N) _____ If Yes, username: _____

Email Address (required): _____

Cell Phone Number (required): _____

Part II: Group Information

Group Name:

Group Address:
(Primary Office)

City, State, Zip:

Phone Number:

Fax Number:

Part III:

User Type:

- e-Prescribing
- Clinical Messaging
- Virtual Health Record (VHR)

Job Category:

- Medical Doctor
- Resident or Intern
- Licensed Health Professional
- Pharmacist

- Technician
- Staff I
- Staff II
- Nurse Practitioner
- Physician Assistant

Part IV: *(This section for MDs and Licensed Health Professionals – including NPs and PAs - only)*

Prescription DEA #: _____ UPIN: _____

NYS License #: _____ NPI: _____
(required)

Quest Client Id #: _____

Verified By (to be signed by the office's Participant Authoritative Source):

PAS name (printed) _____

PAS Signature _____ **Date:** _____

PIN: