



AAA PatientCONNECT™

Portal Enrollment Form

Phone: 1-844-638-7222 • Fax: 1-844-638-7329

*Indicates Required Field

PRACTICE/PREScriBER INFORMATION			
*Practice Name:			
*Ordering Prescriber Name:			
*Licensure Type: Physician Physician Assistant Nurse Practitioner			
*Specialty:			
*Office Address:			
*City:		*State:	*Zip:
*Office Phone:		*Office Fax:	
*Prescriber National Provider Identifier (NPI) No.:		*State License No.:	*Tax ID No.:
<input type="checkbox"/> Check this box to request AAA PatientCONNECT™ portal access for Prescriber.			
*Email:		*Prescriber's Signature:	
Prescribers requesting portal access please sign within the border of the box to process this request. Your signature will be securely stored on the Portal and accessible only to you through the use of your login and password. You will be able to use this electronic signature to process your orders through the portal.			
*Ordering Prescriber Name:			
*Licensure Type: Physician Physician Assistant Nurse Practitioner			
*Specialty:			
*Office Address:			
*City:		*State:	*Zip:
*Office Phone:		*Office Fax:	
*Prescriber NPI No.:		*State License No.:	*Tax ID No.:
<input type="checkbox"/> Check this box to request AAA PatientCONNECT portal access for Prescriber.			
*Email:		*Prescriber's Signature:	
Prescribers requesting portal access please sign within the border of the box to process this request. Your signature will be securely stored on the Portal and accessible only to you through the use of your login and password. You will be able to use this electronic signature to process your orders through the portal.			

REMINDER: You must sign the Facility/Practice Consent form on page 2 to begin the enrollment process.

IMPORTANT INFORMATION

Responsibility for properly submitting claims lies with the health care provider. We make no representation about the eligibility or guarantee of coverage, coding, or reimbursement for any claim. It is the responsibility of the health care provider to choose the most appropriate code as documented in the patient medical record and to submit the appropriate codes, charges, and modifiers for services or items rendered or applied. Use of AAA PatientCONNECT in no way guarantees reimbursement or coverage.

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SITE OF TREATMENT INFORMATION		
*Administering Facility:		Hospital Outpatient Freestanding/ Physician Office
*Facility Address:		
*City:	*State:	*Zip:
*Facility Phone:		*Facility Fax:
*Facility NPI No.:	*Tax ID No.:	

FACILITY/PRACTICE CONSENT	
<p>The Facility/Prescriber/Practice hereby authorizes eMAX Health PAC, the service provider of Advanced Accelerator Applications (AAA) PatientCONNECT™ to use the NPI (National Provider Identifier) and taxpayer ID on their behalf to determine health plan eligibility, perform benefit verification, and provide prior authorization and appeals assistance. AAA PatientCONNECT™'s use of the NPI and Taxpayer ID numbers shall be limited to only those services. AAA PatientCONNECT™ must obtain written authorization from the facility for use outside of the services identified above.</p> <p>By signing this Agreement, I represent and warrant that I am duly authorized and have legal capacity to execute and deliver this Agreement.</p>	
*Printed Name:	*Signature:
*Title:	
<p>Check this box to request AAA PatientCONNECT portal access.</p> <p><input type="checkbox"/> *Email:</p>	

ADMINISTRATIVE USERS		
*Primary Administrative User:		Treatment Facility Prescriber Office
*Name:		
*Office Phone:	Ext:	Mobile Phone:
Fax Number:	*Email:	
*Secondary Administrative User:		Treatment Facility Prescriber Office
*Name:		
*Office Phone:	Ext:	Mobile Phone:
Office Fax:	*Email:	
<p>Each administrator will receive an email invitation to set their unique password and enter the portal. Once they have access, they are responsible to add additional users and delete inactive users as needed.</p>		

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ADDITIONAL USERS		
*User:		Treatment Facility Prescriber Office
*Name:		
*Office Phone:	Ext:	Mobile Phone:
Office Fax:	*Email:	
*User can see only patients for Prescriber(s):		
*User:		Treatment Facility Prescriber Office
*Name:		
*Office Phone:	Ext:	Mobile Phone:
Office Fax:	*Email:	
*User can see only patients for Prescriber(s):		
*User:		Treatment Facility Prescriber Office
*Name:		
*Office Phone:	Ext:	Mobile Phone:
Office Fax:	*Email:	
*User can see only patients for Prescriber(s):		
*User:		Treatment Facility Prescriber Office
*Name:		
*Office Phone:	Ext:	Mobile Phone:
Office Fax:	*Email:	
*User can see only patients for Prescriber(s):		

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