



EZ-Net Access Agreement & User Registration Form

For Non-Contracted Specialists and 3rd Party Billing Companies

Directions: For access to AZPC's EZ-Net System, please complete this form and return it to AZPC's Provider Relations Department via fax at 480-403-8209 or email providerrelations@azprioritycare.com.

This on-line software program is ONLY compatible with Internet Explorer 10 or higher.

PLEASE NOTE: Your request is subject to approval and processing time may take up to 3 weeks. Your account request will be reviewed and access will be considered based on the following: type of group/facility, frequency/amount of claims billed, etc.

INCOMPLETE FORMS WILL CAUSE DELAY IN CREATING YOUR ACCOUNT AND WILL BE RETURNED TO YOU FOR COMPLETION

Please **PRINT** clearly and **COMPLETELY**.

Requestor First Name:		Requestor Last Name:	
Title:	Requestor Phone:	Requestor Fax:	
Practice/Provider Name:			Tax ID# (Required):
Email Address (email address is <u>Required</u> in order for access to be granted):			

ACCEPTANCE OF ARIZONA PRIORITY CARE'S EZ-NET DATA ACCESS TERMS & CONDITIONS

I understand and accept that being granted access to Arizona Priority Care's on-line application, named *EZ-Net* involves my assuming considerable responsibility for maintaining the integrity and security of Arizona Priority Care's data. I am responsible for the privacy and confidentiality of any Arizona Priority Care's data to which I have access.

My signature affixed certifies that I have read and agree to the terms and conditions stated in the first paragraph and will comply with all requirements as directed by Arizona Priority Care.

Requestor Signature (Required):	
Manager/Physician of Group Signature (Required):	Date:

Electronic Signatures Not Accepted

For Third Party Billers: Manager Signatures MUST come directly from the office/group you're requesting access for. Signatures of managers working at your billing company will not be accepted. This is for security purposes and to ensure the group is aware of anyone outside of their office accessing their sensitive billing information.

NOTICE: This communication is intended for the use of the individual or entity to whom it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient, or the employee or the agent responsible for delivering the communication to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone, email or facsimile and disregard this form.

Internal Use Only:			
User Name: _____	Approved: <input type="checkbox"/>	Date: _____	Initials: _____
Contracted Group – Yes: <input type="checkbox"/> No: <input type="checkbox"/>	Denied: <input type="checkbox"/>	Date: _____	Initials: _____
PR Rep: _____	Tracker: <input type="checkbox"/>	Date: _____	Initials: _____
User Guide/PW/UN Sent: Date: _____ Initials: _____	PW Reset: <input type="checkbox"/>	Date: _____	Initials: _____