

Once the information from your office has been verified, we will E-mail you a unique password and link to the web site. We will not send the user name for security purposes in this e-mail.

This authorization is to remain in full force and effect until Provider received written or verbal notification from HealthSmart MSO, Inc. of its termination in such time and in such manner as to afford Provider opportunity to act on it.

Please supply a list of additional Physicians associated with your Office or Billing Office with each Provider signing their initials next to their name:

Provider Name: _____ Signature: _____
Provider Name: _____ Signature: _____
Provider Name: _____ Signature: _____
Provider Name: _____ Signature: _____
Provider Name: _____ Signature: _____
Provider Name: _____ Signature: _____

<p>Please supply the following requested information:</p> <p>(Main contact person can be a PCP, Office Manager, Administrator or Supervisor)</p> <p>**Main Contact Name: _____</p> <p>**Contact Phone: _____</p> <p>**Contact Fax: _____</p> <p>**Contact E-mail: _____</p> <p><small>** All E-mail Addresses and Telephone Numbers will be verified to use web application. All information for verification and password or password re-setting will be sent to Contact.</small></p>
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Fax Application to (714) 947-8708

Or Mail to:
HealthSmart MSO, Inc.
Attn: Remote Access
10855 Business Center Drive, Suite C
Cypress, CA 90630

<u>Internal Use Only</u>	
All Providers Verified by: _____	Date: _____
Provider E-Mail Address Verified by: _____	Date: _____
Provider Phone # Verified by: _____	Date: _____
Contact E-Mail Address Verified by: _____	Date: _____
Contact Phone # Verified by: _____	Date: _____
E-Mail Password and Link by: _____	Date: _____