HOSPICE Rx
A MedTrak Services Solution

Client Online Access Request & Information Worksheet

THIS DOCUMENT MUST BE COMPLETED BY EACH USER FOR EACH TERMINAL WHERE THE MEDTRAK SYSTEM WILL BE ACCESSED.

Name of Software User: _____

Company: _____

Address for Instruction booklet to be mailed to:

_____

City:_____State:_____Zip:_____

E-mail Address: _____

Phone Number: _____

Password Preferred:

_____

(Must be at least 8 characters, with one capitalization and one numeric)

I, _____ certify that I am an authorized agent of the above-indicated Company performing plan administrative functions on behalf of the following health plan: _____. I understand that the information accessed through the MedTrak Services -Pharmscreens program may constitute protected health information (PHI) under the Health Information Portability and Accountability Act (HIPAA); and I certify that all such PHI will be used, disclosed and/or otherwise treated in full compliance with HIPAA as minimally necessary to carry out plan administrative functions, and not for any other impermissible purpose.

_____

(Sign Here)

Once you have *signed & completed* this form, please mail or fax to:

MedTrak Services Attn: Kevin Schellman
7101 College Blvd, Ste 1000
Overland Park, KS 66210
Fax Number: 913-322-8498

MEDTRAK SERVICES INTEROFFICE USE

User Name: _____

Date: _____

Instruction Booklet Sent: _____ Tested ☐

Date Sent: _____ Carrier/Group/Org _____