

HOW TO: Request HealthONE Access using DocuSign

Version 1 - 04/2021

ITG - PSS

Filling out DocuSign

Please note, emails from DocuSign will look like the document is being sent from the Provider Support Specialist Manager (Heather Posener)

1. Go to the [DocuSign link here](#)
2. Enter your name and email in the Requestor field
3. Enter your provider name and email in the Physician field
 - a. NOTE: Once you complete your information, the provider will need to also electronically sign the document
4. Scroll to the bottom and click the “Begin Signing” button

PowerForm Signer Information

Fill in the name and email for each signing role listed below.
Signers will receive an email inviting them to sign this document.
Please enter your name and email to begin the signing process.

Requestor

Your Name: *
Full Name

Your Email: *
Email Address

Please provide information for any other signers needed for this document.

Physician

Name:
Full Name

Email:
Email Address

PSS

Name:
Physician Support Specialist Team

Email:
CODOPhysicianStatus@HCAHealthcare.com

LSC

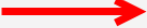
Name:
Diana Martellaro

Email:
Diana.Martellaro@hcahealthcare.com

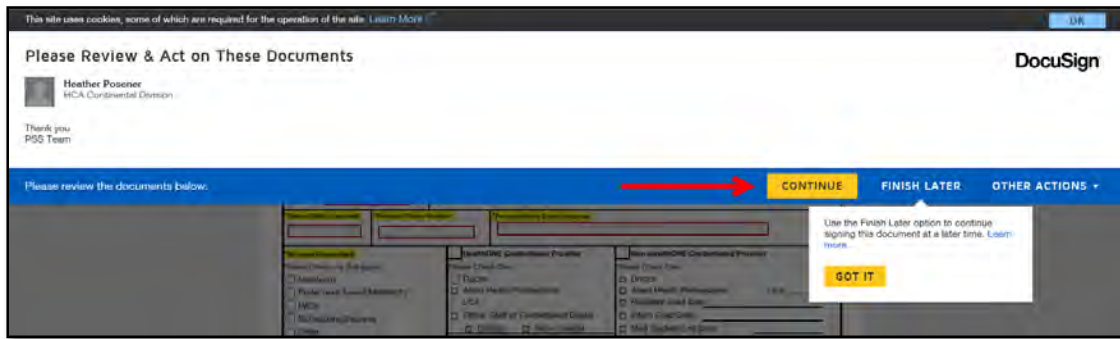
PSS Notification

Name:
Physician Support Specialist Team

Email:
CODOPhysicianStatus@HCAHealthcare.com

 **BEGIN SIGNING**

5. Click “Continue” to enter your information into the Access Form



6. Your name will already be prefilled. Fill in office and demographic information:

- a. HIPAA Compliant Fax #
- b. Office/Work Name
- c. Office Phone Number (no spaces, dashes, etc)
- d. Office Address
- e. Authentication Preference (use dropdown to select)
- f. Home Address
- g. DOB
- h. Personal Phone Number (no spaces, dashes, etc)
- i. Personal/Work E-mail Address


*Last Name:		*First Name:	HIPAA Compliant Fax #:
*Office / Work Name		Office Phone Ext:	*Office / Work Address:
*Authentication Preference (E-mail or Phone): -- select --		*Home Address (including City, State, and Zip Code):	
*Date of Birth: (required)	*Personal Phone Number:	*Personal/Work E-mail Address:	

7. Enter Access Requested:
 - a. Meditech
 - b. Portal (PatientKeeper – web based Meditech)
 - c. PACs
 - d. Scheduling Express
 - e. Other
8. Enter Job Title
9. Enter Action Requested:
 - a. New: create a new HealthONE account
 - b. Add: add new access to existing HealthONE account
 - c. Reactivate: re enable HealthONE access if access is expired or suspended
 - d. Change: update access to new office
10. Primary Facility
 - a. Select facilities you will need access to

*Access Requested: Please Check any that apply: <input checked="" type="checkbox"/> Meditech <input checked="" type="checkbox"/> Portal (web based Meditech) <input type="checkbox"/> PACs <input type="checkbox"/> Scheduling Express <input type="checkbox"/> Other	HealthONE Credentialed Provider Please Check One: <input type="checkbox"/> Doctor <input type="checkbox"/> Allied Health Professional LIC# _____ <input type="checkbox"/> Office Staff of Credentialed Doctor <input type="checkbox"/> Clinical <input type="checkbox"/> Non- Clinical	Non-HealthONE Credentialed Provider Please Check One: <input type="checkbox"/> Doctor <input type="checkbox"/> Allied Health Professional LIC# _____ <input type="checkbox"/> Resident Grad Date: _____ <input type="checkbox"/> Intern Grad Date: _____ <input type="checkbox"/> Med Student End Date: _____ <input type="checkbox"/> Office Staff of Non-Credentialed Doctor <input type="checkbox"/> Clinical <input type="checkbox"/> Non- Clinical	
	*Job Title: <input type="text" value="Medical Assistant"/>	*Providers/Group Name: <input type="text"/>	
Action Requested: <input checked="" type="checkbox"/> New <input type="checkbox"/> Add <input type="checkbox"/> Reactivate <input type="checkbox"/> Change			Primary Facility (If applicable): <input type="checkbox"/> North Suburban Medical Center <input type="checkbox"/> Rose Medical Center <input type="checkbox"/> Swedish Medical Center <input type="checkbox"/> The Medical Center of Aurora <input type="checkbox"/> P/SL Medical Center <input type="checkbox"/> Spalding Rehabilitation Hospital <input type="checkbox"/> Sky Ridge Medical Center <input type="checkbox"/> Swedish Southwest ER <input type="checkbox"/> Centennial Medical Plaza <input checked="" type="checkbox"/> All
I understand the password for accessing the above designated application(s) is to be held in STRICT CONFIDENCE. I also understand willful disclosure of my password or any other user's password or misuse of any password will be considered grounds for termination of access and if applicable, company employment, privileges or engagement.			

11. Enter Supervisor Name and Title
12. Enter Supervisor Email
13. Click the “Sign” button

NOTE: You may have to select a signature if you have not used DocuSign before.

*User Signature: <input type="button" value="Sign"/> 	Date: 4/26/2021	*Physician Signature for Office Staff:
Supervisor Name and Title: <input type="text"/>	Date:	*Physician's Printed Name
Supervisor Email: <input type="text"/>		
Supervisor Signature		

14. You will be taken to the bottom of the Confidentiality and Security Agreement, please read through it before click the second “Sign” button.

NOTE: The name and date should be prefilled.


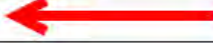
contract, or my relationship ceases with the Company.

26. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.

27. I understand that I have no right to any ownership interest in any Confidential Information accessed or created by me during and in the scope of my relationship with the Company.

By signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Required - Sign Here

*Requestor Signature			Date 4/26/2021
*Requestor Printed Name			

SIGN

15. Click Finish

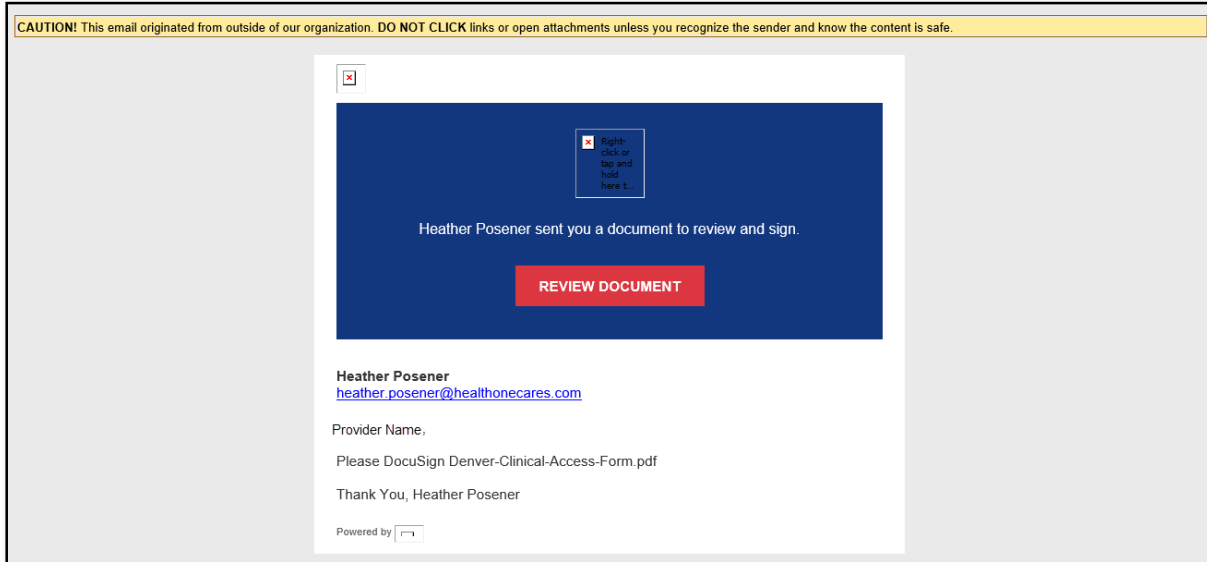
16. Click Close on the pop up and exit the browser.

NOTE: You will get a copy of the completed form once access has been created.

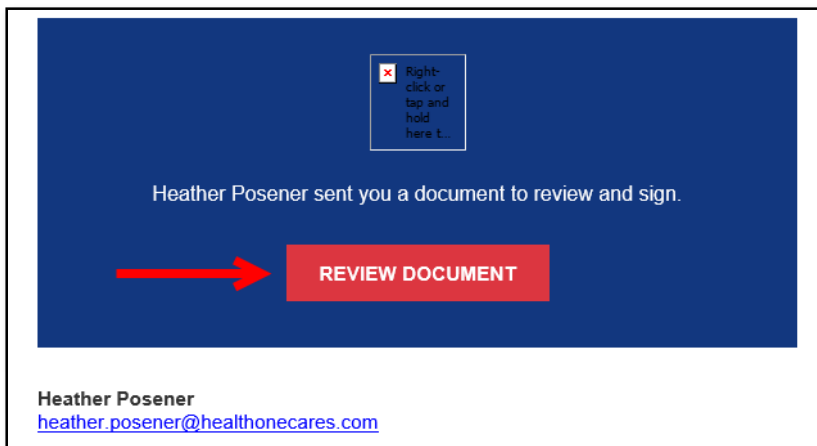
Provider Signing

Provider can sign from mobile device or computer.

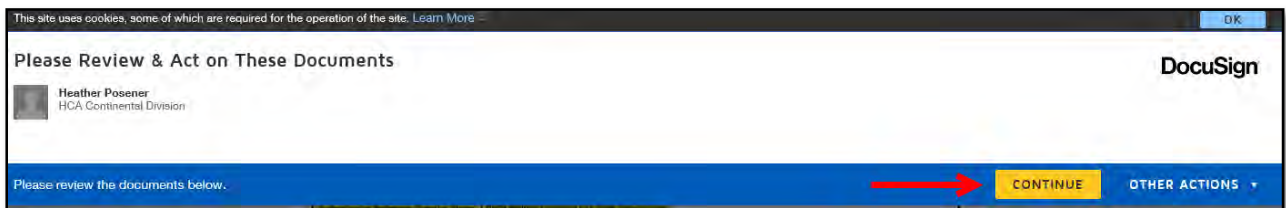
Provider entered in Step 3 will get a notification in their email:



1. Provider will need to click the "Review Document" button



2. Click the "Continue" button



3. Click the “Sign” button

NOTE: Their name will be prefilled in the Physician’s Printed Name area. If they have not used a signature before, they may have to select a one.

I understand the password for accessing the above designated application(s) is to be held in STRICT CONFIDENCE. I also understand willful disclosure of my password or any other user's password or misuse of any password will be considered grounds for termination of access and if applicable, company employment, privileges or engagement.		
User Signature	Date: 4/26/2021	*Physician Signature for Office Staff* Sign ↓
Supervisor Name and Title	Date:	*Physician's Printed Name*
Supervisor Email		
Supervisor Signature		

4. Scroll to the bottom and click the “Finish” button
5. Click Close on the pop up and exit the browser.