



**EZNET USER APPLICATION**  
**USER TYPE: Provider**

Please complete Parts I, II, III, IV. All fields must be completed to establish a User account.

**Part I. Practice Information**  
 PHYSICIAN NAME/GROUP NAME: \_\_\_\_\_  
 LIST PHYSICIANS TO BE ACCESSED: \_\_\_\_\_  
 \_\_\_\_\_  
 ADMINISTRATOR / POINT OF CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

**Part II. User Information**  
 LAST NAME: \_\_\_\_\_ BusinessEmail Address: \_\_\_\_\_  
 FIRST NAME: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Position / Function: \_\_\_\_\_ FAX Number: \_\_\_\_\_  
 Existing EZNet User for different IPA?  Yes  No If Yes, EZNet User ID: \_\_\_\_\_  
 Is user employed by an off site Billing Service?  Yes  No Name of Billing Service/Company: \_\_\_\_\_

**Part III. Confidentiality Statement**  
 Through the EZNet system, the User will have access to confidential patient and financial data. User agrees that State/Federal laws and regulations regarding patient privacy and confidentiality also apply to electronic data. User agrees to maintain the confidentiality of all information received via the MCNet system in accordance with all applicable state and federal laws and regulations.  
 \_\_\_\_\_  
 User Signature

**Part IV. Provider Warranty and Approval**  
 Provider agrees that State/Federal laws and regulations regarding patient privacy and confidentiality also apply to electronic data. Provider warrants that User understands and agrees to maintain the confidentiality of all information received via the EZNet system in accordance with all applicable state and federal laws and regulations.  
 Provider confirms/approves access for the above User.  
 \_\_\_\_\_  
 Provider or Provider Representative Signature

Please fax completed form to (858) 824-7118

**Part V. To be completed by SCPMCS Network Management Department**  
**CLIENT IPA DBASE:**  
 SDPMG  CENTRAL  CFHC  
 ICPMG  NCHS  UPIPA  
**SECURITY:**  Inq. Auth.  Inq. Claim  
 Inq. Elig.  Auth. Req.  Full Claim  
 Full Elig.  Full Auth.  Claim Req.  
 APPROVED: \_\_\_\_\_ DATE: \_\_\_\_\_

**Part VI. To be completed by Information Services Department**  
**USER LOGIN:** \_\_\_\_\_  
**DEFAULT PASSWORD:** \_\_\_\_\_  
 (Note: Default Password must be changed the first time user logs onto MCNet)  
 COMPLETED BY: \_\_\_\_\_ DATE CREATED: \_\_\_\_\_

**Comments:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
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