

in Site	Access Request Form						
Please complete one form for each login desired. Indicate desired eSolutions access.							
Name of Provider(s) or Practice(s):							
Tax ID Number(s):	NPI Number(s):						
User's First and Last Name:							
osci si iist and East Name.							
Title:							
Email Address:							
Mailing Address (Include Full Proties Name 9 Cuit	to Number of						
Mailing Address (Include Full Practice Name & Sui	te Number):						
Technical Lead:	Phone/Fax:						
recimical Lead.	r Hone/i ax.						
Practice Management System:	Electronic Claims Clearinghouse (if applicable):						
Version:							
PC Operating System:	ISP (Internet Service Provider):						
Desired Username (6-10 characters only. No special char	acters *;%# or spaces):						
The following Hill Physicians eSolutions are included in	this acces request:						
	•						
Inquiry/Provider and Practice Resources Please indicate your desire for access to other Hill Physics Please indicate your desired in the Hill Physics Please in the Hill Physi	eAuth Submission sicians eSolutions You will be contacted if further						
Please indicate your desire for access to other Hill Physicians eSolutions. You will be contacted if further information and/or discussion is required.							
☐ Ascender* (Preventive health tracking and outreach system) Currently available only for PCP							
☐ RelayHealth® (A secure online system enabling communication with patients, providers & facilities)							
☐ ERA (dependent on your system's capabilities)							
☐ eEOB (Electronic Explanation of Benefits) We encourage you to go paperless for the environment.							
□ eFT* (Electronic Funds Transfer) We encourage you to go paperless for the environment.							
☐ EHR/EPM (Nextgen) Note: This system is not available through Hill inSite access and requires additional procedures for application and set-up. <i>Providers only</i> may check the box to indicate interest. You will be contacted.							
*You must also complete the Electronic Funds Transfer Verification/Release Form before access is granted.							

Please send the completed form to your Practice Support Representative, or mail it to:

Hill Physicians Medical Group Attn: Practice Support 2409 Camino Ramon San Ramon, CA 94583





Billing Service Authorization Form

This form is required in order for billing services to access Hill Physicians participating provider protected health information (PHI). The billing service must obtain written permission from each practice they service in order to use *Hill inSite* on the practices' behalf.

The following portion should be completed by the billing service:							
Name of Billing Service:							
Address:							
City, State, Zip:							
Hill inSite users: please complete the following:							
Your name:	Hill inSite Username:						
The following portion should be completed by the Hill Physicians Medical Group practice:							
I affirm that I have obtained a business associate agreement with the above billing service and grant them access to Hill inSite and Hill eSolutions on my behalf.							
Name of Provider or Practice:							
Tax ID Number(s):	NPI Number(s):						
(-)							
Authorized Representative (please print name and title):							
Signature:							

Please send the completed form to your Practice Support Representative, or mail it to:

Hill Physicians Medical Group Attn: Practice Support 2409 Camino Ramon San Ramon, CA 94583

If you have any questions, please contact us at inSite.Support@hpmg.com.



Electronic Funds Transfer Verification/Release

I hereby authorize Hill Physicians Medical Group to transfer my claims payments into the account listed below each week. I agree that it is **my** responsibility to provide Hill Physicians with the correct account information. I understand that Hill Physicians will not be responsible for funds unable to be transferred into my account due to incorrect information. Please attach a voided check from the account you wish the funds to be transferred.

Please send the completed form to your Practice Support Representative, or mail it to:
Hill Physicians Medical Group
Attn: Practice Support
2409 Camino Ramon
San Ramon, CA 94583

Hill Physicians must have the original signature and voided check on file before your EFT request can be processed (copies or faxes are not acceptable for processing).

Electronic Funds Transfer set-up may take up to two weeks to take effect.

Practice Name:						Tax Identification Number/ NPI Number:				
Authorized Representative Name (Printed):				Authorized Representative Signature:						
Phone Number: Email Address:				Hill inSite Username:			name:			
Please check the appropriate section: ☑										
□ Please begin Electronic Funds Transfer to the following account: Account Type: □ Checking □ Savings □ Other (specify)										
			Routing	Number			Account Number			
Date:				Initials:						
□ Please change our Electronic Funds Transfer Account to: Account Type: □ Checking □ Savings □ Other (specify)										
Routing Number						Account Number				
Date: Initials:						Effective Date of Change:				
□ Please stop our Electronic Funds Transfer. I wish to receive hard-copy checks.										
Date) :						Initials:			
Office	Use On	lv:								
Received: Dictionaries		Roles Table	Task List	Database	FAX	Set up Date:	Date Live:			
ט	ate	Ву	471	9023	i abie	LIST			•	