



Prescribing Provider Authorization and Confidentiality Agreement for use of the MyOmniSource HCP Portal – Multiple Physician

Dear Prescribing Provider & GH Nurse:

You are invited to register with Omnitrope's on-line patient reimbursement portal, MyOmniSource.

MyOmniSource is a secure, HIPAA-compliant website where you can post and review inquiries with your dedicated Omnitrope Case Manager at your convenience. Once registered with MyOmniSource, you will have instant access to records for every patient you have enrolled in OmniSource.

MyOmniSource was created to facilitate the processing of health insurance information on behalf of patients who have consented to participate in the OmniSource Patient Support Program and have thereby agreed to have their protected health information (PHI) disclosed to coordinate the receipt, payment and administration of Omnitrope.

Use of the system will require that you first accept the Privacy Statement which you will view when you access the portal.

This form must be completed by you and faxed to 1-877-828-1052 in order for you to access the MyOmniSource Portal. Upon acceptance of your registration, you will be contacted and given user information. Access rights to the system are not guaranteed and may be terminated at any time.

Thank you,

Omnitrope Team





Prescribing Provider Authorization and Confidentiality Agreement for use of the MyOmniSource HCP Portal – Multiple Physician

I hereby request that I be provided access to the MyOmniSource Portal (“Portal”). I certify that I submit patient enrollment forms to OmniSource and/or that I am managing the patient and their respective information (which includes but is not limited to patient name, DOB, etc.) that resides within the Portal.

I understand that the information contained in the Portal constitutes PHI under the Health Insurance Portability and Accountability Act. I acknowledge and agree that I may not share my log in name and password or disclose any information I obtain from the Portal with any other individual or entity or use the PHI for any purpose other than to seek payment for the OmniSource program. I agree to report any abuse or misuse of this system to OmniSource.

The GH Nurse identified in **Section 1** will be granted access to the patient’s PHI that belong to the Prescriber(s) identified below in **Section 2** (continued on page 3) of this registration form.

Section 1 – GH Nurse requesting access to the portal:

GH Nurse Name: _____ Email: _____
 Address: _____ City: _____ State: __ Zip: _____ Phone: _____ Fax: _____
 Signed this _____ day of _____, 20__ Signed: _____ Title: _____

Section 2 - Prescriber(s) requesting access to the portal. Also, granting access to their patient’s PHI to GH Nurse in Section 1:

Prescriber Name: _____ DEA #: _____ Email: _____
 Address: _____ City: _____ State: __ Zip: _____ Phone: _____ Fax: _____
 Provider Tax ID: _____ Provider Designation: MD DO NP PA
 Signed this _____ day of _____, 20__ Signed: _____ Title: _____

Prescriber Name: _____ DEA #: _____ Email: _____
 Address: _____ City: _____ State: __ Zip: _____ Phone: _____ Fax: _____
 Provider Tax ID: _____ Provider Designation: MD DO NP PA
 Signed this _____ day of _____, 20__ Signed: _____ Title: _____

Access for additional prescribers may be requested on page 3.

Section 2 (continued) - Prescriber(s) requesting access to the portal. Also, granting access to their patient's PHI to GH Nurse in **Section 1**:

Prescriber Name: _____ DEA #: _____ Email: _____ Address: _____ City: _____ State: __ Zip: _____ Phone: _____ Fax: _____ Provider Tax ID: _____ Provider Designation: MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> Signed this _____ day of _____, 20__ Signed: _____ Title: _____
Prescriber Name: _____ DEA #: _____ Email: _____ Address: _____ City: _____ State: __ Zip: _____ Phone: _____ Fax: _____ Provider Tax ID: _____ Provider Designation: MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> Signed this _____ day of _____, 20__ Signed: _____ Title: _____
Prescriber Name: _____ DEA #: _____ Email: _____ Address: _____ City: _____ State: __ Zip: _____ Phone: _____ Fax: _____ Provider Tax ID: _____ Provider Designation: MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> Signed this _____ day of _____, 20__ Signed: _____ Title: _____
Prescriber Name: _____ DEA #: _____ Email: _____ Address: _____ City: _____ State: __ Zip: _____ Phone: _____ Fax: _____ Provider Tax ID: _____ Provider Designation: MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> Signed this _____ day of _____, 20__ Signed: _____ Title: _____

All fields are required to obtain access to the Portal.
Please fax the completed form to 1-877-828-1052