

MedAllies User Information Sheet

When complete, fax the form to MedAllies at (845) 896-9306. **If you have any questions while completing this form, please call the Help Desk at (845) 896-0191 x 3007.**

Practice Name	
Street Address	
City, State, Zip Code	
Main Telephone Number	
Main Fax Number	

Please have each user fill out **ALL** fields below.

1. User First Name: _____
2. User Middle Initial: _____
(Please provide you middle initial; this initial is included to create a unique ID for you)
3. User Last Name: _____
4. Suffix: _____ (Jr., Sr., III)
5. Title: Mr. Mrs. Ms. Dr.
Job Title: _____
6. Credentials: M.D. D.O. Ph.D. R.N. P.A. N.P. L.P.N. _____
(Check if any apply)
7. Last Four Digits of Social Security Number: X X X- X X - _____
(Required for security purposes)
8. Specialty: _____
9. NYS Medical License Number: _____
(Licensed Healthcare Professionals Only)
10. Prescription DEA Number: _____
(Licensed Healthcare Professionals Only)
11. Medicare UPIN: _____
(Licensed Healthcare Professionals Only)
12. 12. NPI Number: _____
(Licensed Healthcare Professionals Only)

Check here if you have received a copy of the privacy statement.

FOR PHYSICIANS ONLY:

(Check all that apply)

Check here if you are interested in signing your reports electronically on the MedAllies website.

Affiliated Hospitals Kingston Benedictine St. Francis Vassar NDH

Affiliated Labs: Enter Account # LabCorp _____ Quest _____

For Office Use Only

Date Received: _____ Date Entered: _____ Entered By: _____

Quest ID sent to HEALTHvision