INSTRUCTIONS
ELECTRONIC FILING USER ID AND PASSWORD APPLICATION

All providers licensed under Article 28 are required to pay an assessment on cash operating receipts. The monthly assessment payments are due to the Pool Administrator within 15 days following the end of each calendar month to which the assessment applies. A website has been established at www.hcrapools.org to facilitate this process.

While electronic filing is designed to be user friendly, a help desk has been established to aid those users requiring assistance. If you need general assistance or assistance in obtaining copies of the electronic filing screens and the electronic reporting certification forms, please contact the help desk at (315) 671-3800 or via e-mail at webpools@hcrapools.org.

Upon receipt of this form, the Office of Pool Administration will assign a secure electronic filing user ID and password to your organization, which you will receive via return mail.

New Request/Revision to Existing Account: Check the appropriate box. An entity requesting an initial account/password should check the *New Request* box; an entity that has an existing account and is advising the Department of a change to that account should check the *Revision to Existing Account* box.

Provider Name: Enter name of entity that will be submitting the reports electronically.

Federal Tax ID #: Enter federal employer tax identification number assigned to the entity named above.

Operating Certificate #: Enter Operating Certificate number assigned by the Department of Health to the entity named above.

MMIS # : Enter the MMIS # assigned by the Office of Medicaid Management to the entity named above.

Type of Facility: Enter a check mark in the appropriate box, hospital or nursing home.

Signature: Must be signed by the Chief Executive/Financial Officer and/or Administrator of the entity named above.

Name/Title/Phone Number (Please Print): Enter name, title and phone number of the person signing above.

Address/City/State/Zip Code: Enter address of the person signing above.

E-mail Address: Enter e-mail address of the person signing above.

Date: Enter date this form is signed.

ELECTRONIC FILING USER ID AND PASSWORD APPLICATION

☐ **New Request** ☐ **Revision to Existing Account**

Provider Name: ____

Federal Employer Identification # (FEIN):______________________________

Operating Certificate # : ______________________________________

MMIS # : ____

Type of Facility (check appropriate box):

☐ Nursing Home

☐ Hospital

By signature below, the Chief Financial Officer or other duly authorized individual of the above named entity authorizes the Office of Pool Administration to assign a secure electronic filing user ID and password to the entity. This information will be mailed directly to the attention of the signer and must remain secured. It is the responsibility of the above named entity to ensure that this information is released only to those individuals requiring knowledge thereof.

Signature ____

Name (Please Print) ______________________________________

Title ____

Phone Number ____

Address ____

____

City ______________________ **State** __________ **Zip Code** ____________

E-mail Address ____

Date __________________

Note: All fields on this form are required to be accurately completed in order for your request to be processed.

Please mail completed form to:
Mr. Jerome Alaimo, Pool Administrator
Office of Pool Administration
Excellus BlueCross BlueShield, Central New York Region
P.O. Box 4757
Syracuse, New York 13221-4757