



Preferred Care System Access Information Form

Today's Date: \_\_\_\_\_

Page: \_\_\_\_\_ of \_\_\_\_\_ Pages

Each office to complete (one form for each office)

Utilize as many sheets as necessary to document all persons

Provider / Practice Name : _____	
Provider Tax ID Number(s) : _____	
Primary Office E-mail Address : _____	
Office Street Address : _____	Office Phone Number : _____
Primary Office Contact Full Name : _____	Primary Contact Phone Number : _____
Alt. Office Contact Full Name : _____	Alt. Contact Phone Number : _____
Practice Mgmt. (PM) Vendor Name: _____	FAX Phone Number: _____

**Instructions**

1. Each provider office **must** provide a primary and, if available, an alternate office contact who is responsible to manage *easyLink* access for the users in the office. This is the person who should fill out the information and users on this form.
2. The primary or alternate office contact persons are the only ones who can call and change access capabilities for the users identified in the office.
3. The office contact must validate the minimum level of access for each user.
4. If a provider has several offices (addresses), fill out one sheet for each separate office location identifying the applicable contacts.
5. List the users at each office needing access to *easyLink* (see the reverse side of this form). Copy this form if more space is required to identify additional offices or office staff.
6. Mail the completed form(s) back to Preferred Care in the provided postage paid envelope to:

**Preferred Care**  
**E-Support Application Security Administrator**  
**220 Alexander St**  
**Rochester, New York 14607**

**Or Fax** the completed form to **585-258-8071**.

If you have any questions regarding the information or instructions on this form, please contact the Preferred Care E-Support Line Monday through Friday from 8:00 a.m. until 5:00 p.m. at 585-327-2239, option 2, or e-mail [pceasy@preferredcare.org](mailto:pceasy@preferredcare.org).

→  
**List All Users On The Back Of This Form**





Name \_\_\_\_\_

Office Name \_\_\_\_\_

Direct Phone # \_\_\_\_\_

### Passcode Request Form

Please complete this form in order to access Preferred Care's electronic options.

Create a strong, unique passcode consisting of 8 characters with a **minimum** of:

- 1 alpha character (a – z) – not case sensitive
- 1 numeric character (0 – 9)
- 1 special character from the following list: !, @, #, \$, %, &, \*, +, and \_.

**Tip:** To create a strong, easily remembered passcode, choose a phrase that has significance and use the first letter of each word, substituting numeric and special characters for some words. **Example:** My favorite dinner is one pound of Shrimp. The passcode could be "Mfdi1#oS".

**\*Desired Passcode**

**Please print clearly.**

\_\_\_\_\_

\*Please note: passcode **MUST** contain at least 1 alpha and numeric and special character

**Note: Retain a copy of your passcode, protect it, and do not share your passcode with anyone.**

**User Validation Information** (In the event you forget your passcode, we need another piece of information unique to you to verify your identity.)

What is your mother's maiden name? \_\_\_\_\_

Please fax this form back to E-Support at Preferred Care at (585) 258-8071.

If you need to change your passcode, contact Preferred Care E-Support at (585) 327-2239, option 2, or e-mail [pceasy@preferredcare.org](mailto:pceasy@preferredcare.org).