New Practice Registration Form

Full Legal Practice Name *

Should Match name on NPI

DBA (Doing Business As)

If you are known by a separate name, please let us know here

Physical Address of the Main Practice Location. We need this in order to create your personalized platform on Medical Office Force *

Street Address

Street Address Line 2

City | State / Province

9 Digit Zip Code *

Look up 9 Digit Zip Code on USPS Website

County *

Practice Phone Number *

This is the number that we will connect to our platform for Caller ID. It will make it look like we are calling your patients from this number.

Practice Specialty *

Helps us focus on specific chronic conditions based on your specialty.

Note: Medical Office Force will only submit claims for the services that we provide (RPM, CCM, RTM, TM) This needs to be filled by billing manager, this is very important that we have the correct Grp TAX Id, Grp NPI, and Grp Ptan. Please make sure we do not mixed grp Id's with Indivdual Id's.

Group Tax ID *

This is used for billing purposes.

Group NPI *

This is used for billing purposes

Group PTAN *

This is used for billing purposes (TYPICALLY 6 DIGITS)

Medicare Provider

Used for billing purposes,

Physician Information

This information will be used to create a Physician account in our Medical Office Force Platform. This account will allow the physician to access their personalized platform through our web-based dashboard or through our Physician app. The physician will need to access the platform to view their patient population, view and clear escalations, & securely message patients, MOF Staff, and Clinic Staff.

Provider Name *

First Name Last Name

Suffix *

Title

Physician Cell *

Please enter the Physician's PERSONAL Cell

Physician Email *

Please enter the physician's personal email. We use this email to reset their password in case they ever forget.

Individual NPI Number *

Make sure this is not the same as the group NPI!

Individual PTAN *

Make sure this is not the same as the group PTAN!

The Signature below will be used to electronically sign off on the RPM and CCM reports for billing purposes.
THIS WILL BE USED FOR BILLING PURPOSES, PLEASE MAKE SURE YOUR SIGNATURE IS OFFICIAL FULL SIGNATURE

Signature

EMR Platform

We need to know what platform you are using since we will require access to it.

Thank you for your submission of the MOF order form and for agreeing to the Terms & Conditions.

- We would like to inform you that the next crucial step in the implementation process involves the completion of the new practice registration form.
- This form is essential as it will enable us to generate your Medical Office Force dashboard and credentials, establish your escalation protocols, and obtain access to your Electronic Medical Records (EMR) system.
- We would like to emphasize that the information contained within these documents is of a confidential and privileged nature, intended solely for the designated recipient.
- Any unauthorized use, publication, or redistribution of this information is strictly prohibited without prior written consent from the practice. Rest assured, the form provided is encrypted and highly secure to safeguard against any potential misuse or unauthorized access to the information you provide below.

EMR Platform URL

For Web-based/Cloud-based EMR. URL needed to be able to access the platform.

Practice Website *

Displayed on your Medical Office Force Platform. N/A if not Applicable.

Administrator Email

example@example.com

Email Address *

Please enter the groups contact email address.

Billing Method: Would you prefer that Medical Office Force (MOF) bill your claims or will you bill the claims yourself?

- ○ MOF
- ○ Self

Administrator Phone Number *

Please enter a valid phone number. PERSONAL Cell phone for the Practice Administrator.

The Signature below will be used to electronically sign off on the RPM and CCM reports for billing purposes.

Physician Email

Our **IT** department needs ***admin access*** in order to import your patients to our MOF platform. We will need access to the reporting feature on your EMR. This will allow us to do a practice analysis of your practice. An alternative to this is to provide the patient data to us in a CCDA download.
Our **Billing** department will need ***view-only access*** in order for them to verify insurances and so they can begin to qualify your patients.
Our **Administration** department will need ***view-only access***.
Our **Registration** department will need ***view-only access*** so they can confirm addresses, diagnoses, and insurance before they register patients.

Name	Department	Date of Birth	Email
Leo Matiz	IT	12/17/1994	leonidas.matiz@healthwealthsafe.com
Rahul Gupta	Billing	01/01/1981	rahul.gupta@healthwealthsafe.com
Dawn Dobbs	Administration	08/10/1975	dawn@ahcspc.com
Santosh Shah	Registration	08/10/1979	santosh.shah@healthwealthsafe.com
Mamta Parikh	Registration	06/15/1977	mamta.parikh@healthwealthsafe.com

The Password for each user should be: **Summer@2022**

Practice Administrator *

First Name Last Name

Name

First Name Last Name

Physician Cell

Please enter a valid phone number.

Practice Fax Number *

We use this Fax in order for us to fax your practice the care plans that our Care Managers create for your patients.

Physician Email

Individual NPI Number

Do you have multiple locations in your practice? *

- ◯ Yes
- ◯ No

Physical Address of the Practice. We need this in order to create your personalized platform on Medical Office Force *

Street Address

Street Address Line 2

City | State / Province

9 Digit Zip Code *

Look up 9 Digit Zip Code on USPS Website

County *

Practice Fax Number *

We use this Fax in order for us to fax your practice the care plans that our Care Managers create for your patients.

Individual PTAN

Escalation Contact Email *

example@example.com

Select Preferred Device Distribution (Which devices would you like us to distribute?) Select at least one or all three. *

- [ ] Blood Pressure Monitor
- [ ] Glucometer
- [ ] Weight Scale

High Diastolic *

- ◯ Default: Greater than 90 mmHg
- ◯ Other

High Blood Sugar *

- ◯ Default: Greater than 180 mg/dL
- ◯ Other

High Systolic *

- ◯ Default: Greater than 159 mmHg
- ◯ Other

The standard escalation protocol for **Weight Gain or Loss** is as follows. This means that receiving a device reading surpassing these thresholds will trigger an alert and potential escalation to the physician. Please select the Default Protocol or set your own parameters for each category. *Please note, if you choose your own parameters, you will automatically get alerted through an escalation everytime there is a reading that surpasses the thresholds you set. **Changing escalation protocols outside of system defaults will send all "Needs Attention" readings to the Escalation Dashboard, bypassing MOF intervention. Contact your account manager with any questions.**

Billing Department EMR Access

Username Access

Name

First Name Last Name

Suffix

Title

Physician Cell

Please enter a valid phone number.

Individual NPI Number

Individual PTAN

The default escalation protocol for **Blood Pressure** is as follows. This means that receiving a device reading surpassing these thresholds will trigger an alert and potential escalation to the physician. Please select the Default Protocol or set your own parameters for each category. *Please note, if you choose your own parameters, you will automatically get alerted through an escalation everytime there is a reading that surpasses the thresholds you set. **Changing escalation protocols outside of system defaults will send all "Needs Attention" readings to the Escalation Dashboard, bypassing MOF intervention. Contact your account manager with any questions.**

The Signature below will be used to electronically sign off on the RPM and CCM reports for billing purposes.

Low Systolic *

- ○ Default: Lower than 101 mmHg
- ○ Other

The standard escalation protocol for **Blood Sugar** is as follows. This means that receiving a device reading surpassing these thresholds will trigger an alert and potential escalation to the physician. Please select the Default Protocol or set your own parameters for each category. *Please note, if you choose your own parameters, you will automatically get alerted through an escalation everytime there is a reading that surpasses the thresholds you set. **Changing escalation protocols outside of system defaults will send all "Needs Attention" readings to the Escalation Dashboard, bypassing MOF intervention. Contact your account manager with any questions.**

Additional Escalation Notes

Please provide any additional protocols that you would like for us to follow.

Suffix

Title

Escalation Protocols

In this section, you will create your escalation protocols. You will appoint a primary escalation contact. This will be the primary person that we contact with any escalations and patient concerns. This could be the physician or someone from your practice. You will also choose devices, set protocols, and provide any other additional protocols you would like us to follow.

In order for us to begin enrolling your patients in RPM & CCM, we need accurate patient data to qualify each patient. This patient data will also help us in creating care plans for your patients. We ask that you provide this Patient information from your EMR and clearinghouse via a CCDA download of the data. We can also assist you in downloading this information by providing our IT team with Admin Access for a limited time. The following data is what we require in order to qualify and enroll your patients:

- Current Patient Demographics (including address, phone number, etc.)
- Last office visit (this will help us so we know not to register inactive patients)
- Diagnosis (this will help us qualify the patient for either program)
- Current Health Insurance (this will help us qualify the patient for either program)
- Next of Kin or caregiver information (this will help us in creating a care plan for the patient)
- Current Medication (this will help in creating a care plan for the patient)
- Preferred Language (this will help us so we know to provide service in the preferred language if applicable)

We also ask that we get view-only access to your EMR so we can confirm information before we call the patient. This will also help us register any new patients that want to enroll after the initial data download. We don't want to make any changes to your EMR so we only ask for VIEW-ONLY access. Below is a list of users who would need access to the EMR.

Low Diastolic *

- ◯ Default: Below 51 mmHg
- ◯ Other

Spanish Voice Shot!

If you have a large Spanish Speaking Population, record a Spanish language voice shot below.

EMR Practice ID/ Account #

If the EMR requires a practice ID or account # to login.

Estimados pacientes,

(Esto es, Nombre de la práctica)

Estamos pidiendo a todos nuestros pacientes que se registren en Medical Office Force, un servicio de control remoto de pacientes para ayudarnos a controlar su salud y bienestar entre sus visitas regulares al consultorio.

Medical Office Force se puede usar en su teléfono inteligente o en su teléfono fijo de casa.

Un administrador de atención de Medical Office Force se comunicará con usted para registrarse y capacitarlo sobre cómo usar el servicio.

Como participante en nuestro programa de monitoreo de pacientes, calificará para hasta tres piezas de equipo médico. Una báscula para medir y controlar su peso corporal, un monitor de presión arterial y un glucómetro para controlar su nivel de azúcar en la sangre junto con un suministro continuo de tiras

reactivas y lancetas gratis.

Comuníquese con Medical Office Force al 1-877-581-8810 si tiene preguntas sobre este servicio.

Esperamos trabajar con usted en el control remoto de su salud.

Please ensure that all of the required information above is complete & correct before submitting.

If you don't complete the form, you have the option to save your progress using the save button. It will ask you to make a "jotform" account so that you can came back and finish it at a later point. Our implementation team will contact you when we receive the form to begin the implementation process. We look forward to partnering with you to monitor your patients!

Escalation Contact Phone Number *

Please enter a valid phone number.

Practice Administrator

This is the person that we will contact with any information about this practice. We will also create a "Site Admin" account in MOF for this person. As a "Site Admin" they will be able to create and deactivate additional staff accounts for the practice. For example, they will be able to create office staff "Clinic Care Manager" accounts for them to access their patients on the MOF dashboard.

Weight Gain within 7 day period *

- ○ Default: 10 lbs or greater
- ○ Other

IT Department EMR Access

Username Access

Administration Department EMR Access

Username Access

Voice Shot!

In order for us to have a higher chance at registering your patients with Medical Office Force, we do an introductory call with a pre-recorded message from the physician or someone recognizable from your office. Use this form to record the voice shot. Use the script below for guidance.

Escalation Contact *

First Name | Last Name | Suffix

Low Blood Sugar *

- ○ Default: Below 69 mg/dL
- ○ Other

Weight Loss within 7 day period *

- ○ Default: 10 lbs or greater
- ○ Other

Registration Department EMR Access

Username | Access

Dear Patients,

This is your doctor, [Dr. Name], with [Practice Name]

I'm happy to inform you that we have partnered with Medical Office Force, a Digital Health Platform, to help monitor your health and wellness in between your regular office visits. Remote Patient Monitoring and Chronic Care Management are covered by most health insurance plans.

A Care Manager from Medical Office Force will be contacting you to explain the services and assist with the enrollment process.

As a participant in this program, you will qualify for up to three medical devices. A blood pressure monitor, a bariatric weight scale, or a glucometer which includes a lifetime supply of strips and lancets.

I believe adding these services will help me keep you healthier and identify problems before they become serious.

Once again, I am [Dr. Name] asking you to enroll in these new services. I will explain more about these services at your next appointment, however, for now, contact Medical Office Force at 1-877-581-8810 for any additional questions.