



Provider Super User Registration for thehealthplan.com
 All fields must be completed. Please allow 6 business days for processing.

PLEASE PRINT

New

Change

Section 1: Group / Facility Demographic Information

Group / Facility Name: _____
 Company Mailing Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone: _____ Fax: _____ Tax ID: _____

Section 2: Super User Information

Full Name: _____ Title: _____
 E-mail Address: _____ Phone: _____

Section 3: Requester Information

I agree to have the above named person act as Super User for our company to access the secured Provider section of thehealthplan.com with all rights and responsibilities, including allowing other employees to access the secured Provider section of the website by creating accounts for them. Accounts will not be shared. If this person should leave the organization, I agree to notify Geisinger Health Plan immediately. **Note: The Office Manager may sign as the Contract Executor if they are the designated representative and have decision authority for this site.**

 Name of Contract Executor (Print):

 Signature of Contract Executor:

Email this form to your Provider Manager Representative. Call your regional rep if you don't know their address:
 Danville: (800) 876-5357, Harrisburg: (888) 281-5338, Scranton: (800) 350-6486, State College: (888) 669-4834

The super user will receive an email from "GHP WebDataCoordinator" containing registration information and an Administrative Manual. Medical Policies will be available with completed registration.

To Be Completed by Geisinger Health Plan Only

Super User Needs Access To:	Service Center	Member Health Alerts	
Primary: _____	Tax ID	Office	Provider
Secondary: _____	Tax ID	Office	Provider
Secondary: _____	Tax ID	Office	Provider
Secondary: _____	Tax ID	Office	Provider

I attest that the Contract Executor/Office Manager signature is valid.

Date: _____

 Name of Provider Relations Representative

 Signature of GHP Provider Relations Representative