

<p style="text-align: center;">Agency for Health Care Administration ITOP Monthly Report</p>

Provider User Instructions

User Enrollment

- Review the ITOP Provider User Account Agreement.
- Complete the ITOP Provider User Account Agreement providing all requested information.
- Include signature of user and facility administrator, attach copy of provider license and return it by fax to (850) 922-4351 or by mail to the AHCA licensure unit:

Agency for Health Care Administration
Hospital & Outpatient Services Unit
Mail Stop # 31
2727 Mahan Drive
Tallahassee, FL 32308

User Codes and Passwords

Upon receipt of the ITOP Provider User Account Agreement, the Agency will review the form for completeness. Once the form is deemed complete, a user code and temporary password will be issued. The user will be notified, via the email address provided, of the user code and temporary password. Upon the user's first logon, the user will be asked to accept a disclaimer and then prompted to change the user's password. All user passwords should be kept confidential and should not be shared with anyone.

**Agency for Health Care Administration
ITOP Provider User Account Agreement**

FORM SHOULD BE COMPLETED LEGIBLY AND IN ITS ENTIRETY

AHCA License #: _____

Provider Name: _____

Provider Physical Address: _____

Provider Mailing Address: _____

User Name: _____

Title: _____

Phone Number: _____

Email Address: _____

As an ITOP user I agree to abide by the following:

- I will not disclose or lend my USER CODE AND/OR PASSWORD to anyone. They are for my use only and will serve as my “electronic signature”. This means that I may be held responsible for the consequences of unauthorized or illegal transactions.
- I will not browse or use this information for unauthorized or illegal purposes.
- I will not make any disclosure of this data that is not specifically authorized.
- I will not intentionally cause corruption or disruption of ITOP data.
- If I become aware of any violation of these security requirements or suspect that someone may have used my user coder or password, I will immediately report that information to the appropriate division of the Agency for Health Care Administration (Hospital & Outpatient Services Unit 850-412-4549).

I understand that as an ITOP user, I can submit information electronically on behalf of this Provider. By accessing this system, I am agreeing to follow the Agency for Health Care Administration policies regarding acceptable use and protection of confidential information. By submitting electronic information, I affirm that the information submitted is true. **By agreeing I acknowledge that I have read and understand the terms of this User Account Agreement.**

I Agree to the Terms of this User Account Agreement

User Name (Print)

User Signature

Date

Administrator Name (Print)

Administrator Signature

Date

Mail Form To: Agency for Health Care Administration
Hospital & Outpatient Services Unit, Mail Stop # 31
2727 Mahan Drive
Tallahassee, FL 32308