KHSC Network Access Request Form

KHSC Bundled Care - Payment Portal

Date of Request:Date

First Name: First Name Last Name: Last Name

Job title: Title

Organization / Service Provider: Organization

Email address: Email

Office phone number: Office number Mobile number (optional): Mobile number

Your Username will be emailed to you. Please confirm whether you prefer the Password be texted to you at the above mobile number or if you prefer we call you:

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| Choose an item. |

## Agreement

If you request Bundled Care Payment Portal access you agree to, and have the authority to commit to the following:

* I agree to accept referrals from KHSC for elective unilateral hip and knee patients for post-operative rehabilitation services.
* I agree to ensure that the accepted elective unilateral **knee** replacement patients are seen within 7 days of discharge, as per the Rehabilitation Care Alliance best practice guidelines.
* I agree to ensure that the accepted elective unilateral **hip** replacement patients are seen within 2-6 weeks of discharge, as per the Rehabilitation Care Alliance best practice guidelines.
* I acknowledge having received pricing information and being paid the amounts for the type of services my company provides (e.g. outpatient, inpatient or homecare rehabilitation).
* If uploading Notice(s) of Completion of Care, I confirm that the care plan has been completed for the patient’s episode of care and that I have not requested payment from any other source for the care related to the claimed treatment.

Please complete all of the above information and submit your access request form via email to the KHSC Service Desk: [KHSCITAccessRequests@kingstonhsc.ca](mailto:KHSCITAccessRequests@kingstonhsc.ca).

If you have any questions or concerns regarding the completion of this form, please contact the KHSC Service Desk at 613-549-6666 ext. 4357.