

## AFMC Web Review System Registration Form Field Descriptions

### Access Request

Request Date	<b>REQUIRED.</b> The date the AFMC Web Review System Registration Form is filled out (MM/DD/YYYY).
First Name	<b>REQUIRED.</b> The first name of the person for which the Web Review System access request is requested (from this point on referred to as the user).
Middle Initial	The first initial of the middle name of the user.
Last Name	<b>REQUIRED.</b> The last name of the user.
E-mail Address	<b>REQUIRED.</b> The user's e-mail address at their organization.
Job Title	<b>REQUIRED.</b> The job title of the user.
Employer Name	<b>REQUIRED.</b> The name of the organization where the user will access the Web Review System.
Medicaid Provider #	<b>REQUIRED.</b> The provider number of the organization where the user will access the Web Review System.
Employer Address	<b>REQUIRED.</b> The address of the organization where the user will access the Web Review System.
Work Phone #	<b>REQUIRED.</b> The work telephone number of the user.
Extension #	The work telephone extension number, if applicable, of the user.
Fax #	The fax number of the organization where the user will access the Web Review System.

Security Question

**REQUIRED.** A question that is easily answered by the user that would be difficult for others to answer. Write the correct answer next to one of the question choices: City of birth, Pet's name, Mother's maiden name. This question is used for security and password validation purposes should the user forget their password.

Answer

**REQUIRED.** The answer to the user's security question.

Signatures Required (**REQUIRED** for approval)

Requestor

**REQUIRED.** The signature of the user. The user must sign in the presence of a Notary.

Date

**REQUIRED.** The date the Web Review System Registration Form is signed by the user (MM/DD/YYYY).

Notary Public

**REQUIRED.** The signature of the Notary Public who notarizes the form.

Date

**REQUIRED.** The date the Notary Public signs the form (MM/DD/YYYY).

# AFMC Web Review System Registration Form



**\*NOTE: All fields marked with asterisks are required and must be completed to obtain approval.**

## Access Request

**\*Request Date:**

**\*First Name:**

**Middle Initial:**

**\*Last Name:**

**\*E-Mail Address:**

**\*Job Title:**

**\*Employer Name:**

**\* Medicaid Provider #:**

**\*Employer Address:**

Street

City

State

Zip

**\*Work Phone #:**

**Extension #:**

**Fax #:**

## Security Question

**\*(Answer Only One of the Following)**

City of birth \_\_\_\_\_

Pet's name \_\_\_\_\_

Mother's maiden name \_\_\_\_\_

## Signatures Required

**\*As The Assigned Notary Public I have used the following ID as verification**

Drivers License  Passport  Other: \_\_\_\_\_

**\*Requestor:**

**\*Date:**

**\*Notary Public:**

**\*Date:**

## AFMC Security Use Only

**Group:**

**Access Level:**

Mail completed original forms to: Attn: D.J. Blaylock

AFMC  
PO Box 180001  
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