Attestation B
Imaging Provider Location Enrollment for IX Services
Phase 2 Milestone 1A

New York eHealth Collaborative (NYeC)
Image Exchange Program

Name of QE/HIE: _____

Name of Head Organization for Image Provider Location(s):
(Lead Organization) _____

Name of additional shared Imaging Provider Locations/sites:
(Only fill out if there are locations that exist underneath the head organization)

_____

_____

Indicate the size of the new enrolled Imaging Provider location and if there are multiple shared locations being on boarded through the Image Exchange program.

Imaging Provider Location Size enrolled in IX Program	Check Size of Practice	# of reporting locations on boarded
Large Radiology or Cardiology IX Provider Locations (Between 100k and 300k exams per year)		
Medium Radiology or Cardiology IX Provider Locations (Between 24k and 100k exams per year)		
Small Radiology or Cardiology Imaging Provider Locations (Less than 24k exams per year)		
Add'l Shared Large Imaging Provider Locations (Between 100k and 300k exams per year, total IX volume cannot exceed 300k exams per year)		
Add'l Shared Medium Imaging Provider Locations (Between 24k and 100k exams per year, total IX volume cannot exceed 100k imaging exams per year)		
Add'l Shared Small Provider Locations (Less than 24k exams per year, total IX volume cannot exceed 24k exams per year)		
EKG Connections (500 or more EKGs per month per location)		
EKG Connections (Less than 500 EKGs per month per location)		

Image Provider Location, on behalf of all the healthcare providers at the Image Provider location, agrees to connect with their local QE and install an eHealth Gateway at the location for the purpose of managing the image access through the HIE. The Image Provider Location agrees to install the gateway and implement service and go-live no later than **September 30 2017.** After the integration is complete, Imaging studies will be accessible from the HIE's Clinical Portal in the context of a longitudinal patient record, with image access being managed in accordance with each HIE's existing access controls.

Imaging Provider Representative Printed Name		**Imaging Provider Representative Signature**		**Date Signed**
Title of Imaging Provider Representative				
QE Representative Printed Name		**QE Representative Signature**		**Date Signed**
eHealth Technology representative Printed Name		**eHealth Technology representative Signature**		**Date Signed**

For NYeC Use only Invoice # _____