Community
MENTAL HEALTH
CLINTON • EATON • INGHAM
Together we can.

EXTERNAL PROVIDER ACCESS ADMINISTRATOR REQUEST

TYPE OF REQUEST: NEW ☐ CHANGE ☐ TERMINATE ☐

DATE OF REQUEST: _____

PROVIDER/ORGANIZATION NAME(S): _____

_____

ACCESS ADMINISTRATOR FIRST NAME: _____

ACCESS ADMINISTRATOR LAST NAME: _____

ACCESS ADMINISTRATOR EMAIL ADDRESS: _____

ACCESS ADMINISTRATOR PHONE NUMBER: _____

ACCESS ADMINISTRATOR TITLE/ROLE: _____

WILL ACCESS ADMINISTRATOR REQUIRE SYSTEM ACCESS? YES ☐ NO ☐

WILL ACCESS ADMINISTRATOR REQUIRE CLINICAL REVIEW? YES ☐ NO ☐

If yes, reason: _____

WILL ACCESS ADMINISTRATOR BE SUBMITTING 837 FORMAT CLAIM FILES? YES ☐ NO ☐

The intent of this request form is to monitor who is accessing client information which is protected under HIPAA laws. By utilizing the Provider Access System, you agree to notify Community Mental Health Authority of Clinton, Eaton, and Ingham Counties immediately upon termination of an employee with access to this system.

Any request forms submitted without the proper Authorized Representative's / Access Administrator's signature will be rejected.

_____ _____

Authorized Representative Printed Name **Date**

_____

Authorized Representative Signature