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

# EXTERNAL PROVIDER USER REQUEST

**TYPE OF REQUEST:** NEW ☐ CHANGE ☐ TERMINATE ☐

**DATE OF REQUEST:** _____

**PROVIDER/ORGANIZATION NAME(S):** _____

_____

**USER FIRST NAME:** _____

**USER LAST NAME:** _____

**USER EMAIL ADDRESS:** _____

**USER PHONE NUMBER:** _____

**USER TITLE/ROLE:** _____

**WILL USER REQUIRE CLINICAL REVIEW?** YES ☐ NO ☐

**If yes, reason:** _____

**WILL USER 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/Access Administrator Printed Name** **Date**

_____

**Authorized Representative/Access Administrator Signature**