



ProviderConnect Request for New User Account Form

Community Mental Health of Ottawa County

GENERAL INFORMATION	
Employee Name	
Agency Name	
Agency Address	
Employee Email	
Employee Phone Number	

REQUEST TYPE (Check one and enter the effective date)			
<input type="checkbox"/>	User Addition	Effective Date:	
<input type="checkbox"/>	User Roll Change	Effective Date:	
<input type="checkbox"/>	User Deletion	Effective Date:	

USER ROLE (Check One)			
Mental Health Access		Substance Abuse Access	
<input type="checkbox"/>	Residential Homes	<input type="checkbox"/>	Clinical/Intake (Demographics, TEDS, ASAM, Appts., Auth. Request, Funding, Guarantors, Etc.)
<input type="checkbox"/>	Outpatient Services	<input type="checkbox"/>	Billing (Treatment Entry, Bill Generation, Funding Guarantors)
<input type="checkbox"/>	CLS, Skill Building, Other	<input type="checkbox"/>	Administrative (All Functions)

APPROVAL			
Signature of Requestor		Date:	
Signature of Supervisor		Date:	

Please submit completed ProviderConnect Security Request Forms to Ottawa County Community Mental Health by email (CMHOCpasswordreset@miottawa.org) or fax (616-393-5687).