



User Enrollment Form (Individual Provider (PSW, DE, IC or BC))

Provider Types: 74-749, 83-710, 84-800, 84-801, 84-803

* Indicate Action: <input type="checkbox"/> Add <input type="checkbox"/> Modify <input type="checkbox"/> Deactivate <input type="checkbox"/> Name/Login Change	
* User Name: (Last, First MI) (<i>Print Name</i>)	* Phone:
* Job Title:	* Provider Number(s) (SPD or eXPRS):
* Address: (<i>Mailing Address</i>)	* City, State, Zip:
Include eXPRS login if already assigned	* E-mail Address: (<i>must be your unique email address; it cannot be shared with another eXPRS user</i>)

INSTRUCTIONS: * Indicates required fields. **Send completed form to info.exprs@state.or.us or fax to 503-947-5044.**

If your provider record is active, and the form is complete, your form should be processed within a week of receipt. However, it may take longer, please be patient. Once your account has been created, you will receive a secure email from info.exprs@state.or.us. You will have to set up an account with DHS' secure email system before you can open the email to retrieve your login name and password.

If you have not received an email within one week, please check your junk or spam folder. If it is not received within 10 days, please send an email to info.exprs@state.or.us to check on the status.

Add	Del	Role Name	Information within eXPRS
<input type="checkbox"/>	<input type="checkbox"/>	Provider PSW/DE/IC/BC Claims Manager	<u>View:</u> Claim, Client, Plan of Care, Provider, PSW Menu, Service Authorizations, Service Element <u>Create, Delete, Submit, Update, View:</u> Service Delivery, Travel Time <u>Run:</u> Report – Client Service Authorization

Print Name	
Signature:	Date: / /

Keep a copy of this form for future reference.