Commonwealth of Massachusetts
Department of Mental Health

MHIS USER ACCESS AND PROVIDER REQUEST FORM

Directions:

- **Complete form and send to designated facility/area staff for authorized approval.**
- **Designated facility/area staff will submit signed form as an email attachment to the following distribution lists:**
  - **DMH-DL - IT Requests**
  - **DMH-DL - MHIS USER ACCESS REQUEST**

I. Complete this section for ALL user access requests :

USER NAME: _____ **DATE FORM COMPLETED:** _____

REQUEST TYPE: **New User** **FACILITY:** **Other: please specify in Section V**

PROGRAM TYPE: **Click here to select Program Type** **EFFECTIVE DATE:** _____ **END DATE** (if known): _____

FUNCTIONAL JOB TITLE: (Click on the dropdown categories below to choose the user's functional job title.)

Clinical Job Titles

Job Title A Thru F
Job Title H Thru Pharm
Job Title Phy thru Rehab
Job Title Rehab Thru Z

ACCS/PACT Job Titles
Care Manager Job Titles
Revenue Job Titles
WRAP Job Titles
Other Job Titles

☐ **Inpatient** ☐ **Outpatient** ☐ **Partial Hospital** ☐ **ACCS** ☐ **PACT** ☐ **CM**
(In addition to selecting job title above, check the appropriate boxes for any additional access needed)

☐ **Provider for billing purposes only** – No User Access. (Please complete **Sections VI & VII** below.)

Worcester Recovery Center & Hospital ONLY: ☐ **Inpatient Scheduling** **Select Department** **Select Access Level**

☐ **Other** – please explain or provide detail in **Section V** below.

II. Complete for Case Management Requests Only:

CM SUPERVISOR: _____

For CM supervisor requests, please enter case managers to be assigned to this user in Section V below, if known.

SITE: (Select a single site or multiple sites from the menus below.)

Single Sites - BCA-STA
Single Sites - WBR-WWF
Multiple Site Sets
☐ Other – please specify other site combinations in **Section V** below.

III. Complete for B/AR Requests Only:

HCIS/ BAR DB: (Select all applicable BAR databases for this request.)

☐BAR.BAO Metro Boston	☐BAR.CAO Central MA	☐BAR/MAO Quincy	☐BAR.XAO
☐BAR.NAO Northeast	☐BAR.WAO Western MA	☐BAR.YOS IRTP	☐BAR.SAO3 Brockton
☐BAR.SAO Taunton	☐BAR.SAO1 Corrigan	☐BAR.SAO2 Pocasset	

V. Additional Information: (Please include any details necessary to facilitate processing this request.)

Click here to enter additional info

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VI. Facility-based Provider Identification Section:

For this form, a Provider is defined as an individual working within an inpatient facility or outpatient department or clinic that is providing diagnostic, therapeutic, or other direct services related to treatment (i.e. Physician, Psychologist, Nursing staff, Social Work and Rehab Department staff).

For Non-Clinical User Requests, please **skip** to **Section VII** below.

The following fields must be completed in order to create, edit, or assign an individual identified as a provider within the MHIS provider dictionary.

Provider Name: _____

License # (where applicable): _____ **DEA#** (where applicable): _____

Provider Type: Provider type

NPI is required for a Physician, Psychologist, Nurse Practitioner, Clinical Nurse Specialist, Physician Assistant, Crisis Clinician, and an LICSW:

National Provider Identifier (NPI): _____ Taxonomy Code: _____

Commercial Plan Name: _____ Modifier/PIN: _____

Commercial Plan Name: _____ Modifier/PIN: _____

Commercial Plan Name: _____ Modifier/PIN: _____

Facility / Site Name	Medicare PTAN	Admitting Privileges (check if needed)	Physician Ordering (check if needed)
		☐	☐
		☐	☐
		☐	☐
		☐	☐

VII. Authorization: (This section must be completed for ALL user access requests prior to processing.)

APPROVED BY:

NAME: **(please print)** _____

TITLE: _____ **PHONE #** _____

AUTHORIZED SIGNATURE (required): _____