



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

* Indicate Action: ☐ Add ☐ Modify ☐ Deactivate ☐ Name/Login Change	
* User Name: (Last, First MI) (<i>Print Name</i>)	* Phone:
* Job Title:	* Provider Name or Number (SPD or eXPRS):
* Address: (<i>Mailing Address</i>)	* City, State, Zip:
Already have an eXPRS login name?	* E-mail Address:

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

Add	Del	Role Name	Information within eXPRS
☐	☐	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 <u>Run:</u> Report – Client Service Authorization

Print Name	
Signature:	Date: / /

Maintain form in local file for audit purposes.