



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

* 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 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.** If your provider record is active, and the form is complete, your form should be processed within one week of receipt. However, it may take longer, please be patient. Once your account has been created, you will receive an email from info.exprs@state.or.us. 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 <u>Run:</u> Report – Client Service Authorization

Print Name	
Signature:	Date: / /

Maintain form in local file for audit purposes.