SECURITY REQUEST FORM

*Please complete form and email to helpdesk@streamlinemd.com or fax completed form to **330-800-3540**.*

TYPE OF REQUEST

☐ NEW USER ☐ DEACTIVATE USER ☐ MODIFY USER ☐ REACTIVATE USER

EFFECTIVE DATE: ____________________

Full Name: ____________________

Job Title: ____________________ *Location/Site :* ____________________

Practice Name/ ID: ____________________ *E-Mail Address:* ____________________

☐ **PHYSICIAN**	☐ **MID-LEVEL (NON-PHYSICIAN) PROVIDER (NP, PA, PT, etc.)**	☐ **INCIDENT-TO PROVIDER (NP, PA, PT, etc.)**
☐ Full Time ☐ Part Time ☐ E-Prescribing Privileges DEA #: NPI #: License #: * **Additional Provider setup/fees may apply**	• Will create documentation under their own name • Will bill for services under their own NPI ☐ Full Time ☐ Part Time ☐ E-Prescribing Privileges ☐ Schedule Needed DEA #: NPI #: License #: * **Additional Provider setup/fees may apply**	• Co-signature by physician required • Services will be billed under the supervising physician's NPI ☐ Full Time ☐ Part Time ☐ E-Prescribing Privileges ($99 mo) ☐ Schedule Needed DEA #: NPI #: License #: ☐ **Trusted Agent** (authority to create prescriptions for physician signature) ☐ Scripts ☐ Labs ☐ Diagnostics For provider(s): ____________________ ☐ Check if Training Required ***Additional Support User setup/fees may apply**
☐ **SUPPORT STAFF (Front desk, Nurse, Biller, MA, etc.)** ☐ **Trusted Agent** (authority to create prescriptions for physician signature) ☐ Scripts ☐ Labs ☐ Diagnostics For provider(s): ____________________ * Additional **Support User** setup/fees may apply ☐ Check if Training Required	**SYSTEM ACCESS** *Please check all that apply* ☐ **EHR Login** ☐ **PM+**	If deactivating an individual EHR Login, please specify user name: User Name: ____________________ Indicate current user ID to copy (Note: New user will have access to all databases to which duplicated user has access.) User's ID to copy: ____________________
☐ **RESOURCE** (e.g. Equip., Room…)	☐ **Name Change**	Current Name: ___________ New Name: ___________

APPROVAL AUTHORITY SIGNATURE: ____________________ **DATE:** ____________

E-Mail: ____________________ Full Name: ____________________ Phone: _____

ADDITIONAL INFORMATION / RESTRICTIONS / SPECIAL INSTRUCTIONS:

TO BE COMPLETED BY HELPDESK			
Processed:	*Date:*	*Verified:*	*Date:*