To be completed by Agency Administrative Staff Only

Staff Information:

Name of Staff Member (*Please provide the full legal name)*:

Last Name _____ First _____ MI ___ Agency Tax ID _____

Organization or agency name (if applicable): _____

Job Title: _____ Work eMail Address: _____

Staff Practice Address #1 _____

Staff Practice Address #2 _____

Office Telephone # _____

Office Fax # _____

Do you attest this staff member is either a full or a part time *employee* of the contracted organization? ☐ Yes ☐ No

SmartCare Detail:

Does this employee require a user name and access to the SmartCare system? ☐ Yes ☐ No

Should this staff member be listed in the "rendering" provider drop-down for SmartCare claims? ☐ Yes ☐ No

Does this employee require access to DACODS? ☐ Yes ☐ No

Does this employee require administrative access to reimbursement information? ☐ Yes ☐ No

Date of Hire: _____ Date of Inactivation/Termination: _____

Is the staff member an individual Medicaid Provider? ☐ Yes ☐ No If Yes, Medicaid #:

Is the organization or agency a Medicaid Provider? ☐ Yes ☐ No If Yes, Medicaid #:

Licensed Staff Information:

License/Certification #: _____ License Discipline: _____ (LCSW, LPC, Etc.)

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I certify, agree, understand, and acknowledge the following:

The information provided, including all subparts are complete, current, correct, and not misleading.

_____ _____

Agency Representative Date

SmartCare User Name Date Created:

Return form to: Diversus Health Network, Provider Relations, , P. O. Box 15318, Colorado Springs, CO 80935
barbara.young@DiversusHealth.org