To be completed by Organization/Agency Administrative Staff Only

Organization or agency name (if applicable): ____

Employee Member Information (Please provider the full legal name):

Last Name ______________________________ First ___________________________ MI _____ Date of Birth __________

Job Title: ____

Staff Practice Address #1 ____

Staff Practice Address #2 ____

Work Email Address: ____

Office telephone: ____________________________________ Office fax: _______________________________________

P*lease answer all questions below:*

- Do you attest this staff member is an *employee* of the contracted organization (either full or part time)? Yes No
- Does this employee require a username 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
- Is this employee an individual Health First Colorado Medicaid Provider? Yes No
- Is the organization or agency and Health First Colorado Medicaid Provider? Yes No
- Whose permissions should this person's access mimic? ____

Licensed Employee Information:

License/Certification #: _____________________________________ License Discipline: _______________ (LCSW, LPC, etc.)

License/Certification #: _____________________________________ License Discipline: _______________ (LCSW, LPC, etc.)

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

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

____ _______________________

Organization/Agency Representative Date

RETURN FORM TO: Email: HNDeliverables@DiversusHealth.org
Mail: Diversus Health Network – Attn: Provider Services Manager
P.O. Box 15318, Colorado Springs, CO 80935

Administrative Use Only

SmartCare User Name:____ Date Created: _________________________