PLUMAS COUNTY BEHAVIORAL HEALTH SERVICES

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Contracted Provider Access Request Form

Instructions for Completing Form

Prior to gaining access to the Plumas County Behavioral Health (PCBH) Electronic Health Record (EHR), users must first, submit requests for access and sign a statement of confidentiality.
Additional training in HIPAA, Compliance, as well as Fraud, Waste and Abuse is reccomended, annually.

Type of Request

- **New-** no previous access requested-through any employer
- **Change-** current user ID requires name, license, program, additional or limited access
- **Revoke-** Current User UD no longer needs access to the PCBH EHR systems

Part 1: Required User Information

New Request

- Complete full name and email address
- Complete provider name, phone number, NPI and applicable license. If supervisor, list providers you are requesting access to.

Change Request

- Update applicable information
- If submitting change for Provider (not site) complete Part 2 and 3- (staff with previous ID, new employer)
- If submitting changes for anything other than Provider, skip part 2 and 3(Any change not related to employer)

Revoke Request

- Complete full name and user ID of user needing access revoked

Part 2: Death Master List and Federal Sanctions or Exclusion Monitoring

- Read the Death Master List and Federal Sanctions or Exclusion Monitoring attestation
- Sign where indicated

Part 3: Confidentiality Statement

- Read the confidentiality Statement
- After completing the form, sign where indicated and forward to your local contract coordinator or directly to the QAM at PCBH.

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☐ NEW ☐CHANGE ☐REVOKE USER ID

PART 1: User Information (Please print clearly)

Last name:_____ First Name:_____Middle Initial:_____

Email Address:_____ Direct contact number:_____

Staff NPI:_____ License, if applicable:_____Exp:_____

EHR ID:_____(Issued by PCBH)

Provider Name and Site:_____

If supervising, please list staff to be allowed access to:_____

_____

Part 2: Death Master List and Federal Sanctions or Exclusion Monitoring:
By signing below, I attest that I have never been sanctioned or excluded from participating in a federally funded health care program. I understand that PCBH conducts monthly sanction checks for individuals and entities contracted with PCBH. Sanctions or exclusions may result in a cancellation for the provider contract with PCBH.

User Signature:_____ Date:_____

Part 3: Confidentiality Statement:
I, the undersigned, a designated representative of the provider named above, understand that the approval and assignment of the requested ID or change enables me to access the Plumas County Behavioral Health (PCBH) Electronic Health Record (EHR). I understand that federal and state laws require confidentiality of Plumas County Behavioral Health information and provides penalties for unauthorized access, use or disclosure of this information. I agree to keep confidential all information made available to me through this access. I also agree not to divulge or share my password with anyone.
I agree to use the information obtained through these systems for purposes directly connected with the administration of a federal/state assisted program which provides behavioral health services, directly to individuals on the basis of need. I agree to access only the information needed to fulfill my job duties associated with working with Plumas County Behavioral Health. I further agree to comply with the policies and procedures established by PCBH further governing the access and use of this information.
Violations or disclosures on my part may result in loss of access to the information systems, civil court action, or cancellation for the provider contract with PCBH.

User Signature:_____ Date:_____