Modify

Modify Account or Terminate User
Account Request Form (ARF) - Mental Health Programs

Email form to *MHEHRAccessRequest.HHSA@sdcounty.ca.gov*
and *BHSCredentialing@optum.com*
ALL FORMS MUST BE TYPED AND COMPLETE OR WILL BE RETURNED

Type of Request: Select One

Effective Date:

Program Name: **Legal Entity Number:**

Staff First Name: **MI:** **Last Name:**

Staff ID: **Date of Birth:** **Job Title:**

CHANGES TO UNIT/SUBUNIT ACCESS

Unit:	**Subunit:**	Add/Delete
Unit:	**Subunit:**	Add/Delete
Unit:	**Subunit:**	Add/Delete
Unit:	**Subunit:**	Add/Delete

CHANGES TO CREDENTIAL (Select one option and provide licensing information as appropriate.)

- ☒ **Administrative Staff**
- ☐ **Unlicensed Clinical Staff:** Select for Unlicensed Staff
- ☐ **Licensed Clinical Staff:** Select for Licensed Staff

License or Registration #: **Issue Date:**

NPI #: **Taxonomy #:**

Medcare certified provider, provide PTAN #: **Effective Date:**

COMMENTS (Please provide additional information, regarding reason for Modify ARF.)

PROGRAM CONTACT INFORMATION (where communication to program will be sent regarding ARF)

First Name: **Last Name:**

Email: **Phone:**

Pursuant to the contractual agreement on file with the County of San Diego and as designated by my corporate office, I am authorizing access as noted above and affirm that I have personally reviewed the County's Summary of Policies with the above user.

First Name: **Last Name:** **Date:**

Authorizing Program Manager Signature:

Submit