MHC Computer System Access Request Form

Fax completed Computer System Access Request Form and Confidentiality Agreement to:
Attn: Identity Access Management at 231-935-3215

The user (or Practice Administrator) will be notified via email when the request is complete.
NOTE: Incomplete forms and/or missing information will be rejected

☐ New User ☐ Change Access Level ☐ Change Name ☐ Termination

USER DEMOGRAPHICS:

Primary Email Address:

Legal Name: (Last) (First) (Middle initial)

Residential Home Address:

Social Security # for identity verification (*last 4-digits*): Date of Birth:

ALL FIELDS ABOVE ARE MANDATORY FOR MONITORING PURPOSES

Job Title:

Certification or License (*e.g. MA, LPN, RN*): License Number:

Include proof of certification(s) noted above (if applicable)

Gender: ☐ Female ☐ Male MHC Employed: ☐ Yes ☐ No

Provider NPI Number (*if Provider requesting access*):

Practice Name:

Street address of user's work assignment:

Phone number:

Sponsoring Physician Name: Phone number:

Sponsoring Physician Email:

Practice Administrator: Phone number:

Practice Administrator Email Address:

APPLICATIONS/SOFTWARE: *(please check access needed along with access level)*

☐	**Oracle Health/Cerner**	☐ PowerChart EMR - external (read only) ☐ *Check here if working in a Skilled Nursing Facility* ☐ Procedure Scheduling/RevCycle
☐	**eClinicalWorks**	Practice(s) Needed:
☐	**HealtheIntent**	☐ Office Manager/Super User ☐ Clinical ☐ Care Manager ☐ PHO ☐ Regional Quality Manager ☐ IT Analyst ☐ Informatics ☐ Provider - NPI# _____ Practice(s) Needed:
☐	**Other-Specify Application\Comments:**	

For eligibility questions, email the Physician Liaison team at **PhysicianLiaison@mhc.net**

Revised 05/25