Southwest Michigan BEHAVIORAL HEALTH	**SWMBH MI HEALTH LINK PROVIDER STREAMLINE USER AND RENDERING PROVIDER REQUEST FORM**		
Type of change (circle or highlight one)	ADD / CHANGE / DELETE		
Program / Agency Name and Address			
Date of request		Effective date	
Name of User Last name, First name			
End here and sign request if only deleting staff from system			
Michigan License # Type of License:		Expiration Date	
MCBAP Certification (if applicable)		Expiration Date	
Medicare PIN			
NPI #		Title / Role of user	
Email Address of User		Phone Number	
This person needs user name and password to use system	Y / N	This person is a Rendering Provider	Y / N
Role(s) Circle or highlight all that apply	• Billing/Claims • Clinician (enter client information) • Support Staff (read only)		

_____ _____

Signature of Requester **Date**

I agree to notify Southwest Michigan Behavioral Health of any changes to my professional licensure and /or certification status.

_____ _____

Signature of Applicant ***Date***

Please scan the completed form and email to: providersupport@swmbh.org or fax to: 269.883-6670