Southwest Michigan BEHAVIORAL HEALTH	**SWMBH STREAMLINE MI HEALTH LINK USER AND BILLING 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			
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 • Enter Clinical information (authorization requests, releases, etc.) • Clinical information READ ONLY		
Complete section below for all Billing Providers, even if they will not be using the system.			
Michigan License # Type of License		Expiration Date	
MCBAP Certification (if applicable)		Expiration Date	
Medicare PIN / PTAN (if billing Medicare)			
NPI #		Title / Role of user	

I agree to notify Southwest Michigan Behavioral Health immediately if the individual named above ends employment with the Program/Agency listed, or transitions to a position in which access to the SWMBH Streamline system is no longer necessary for job functions.

Signature of Requester **Date**

I verify that the above information is complete and accurate. I agree to immediately notify Southwest Michigan Behavioral Health of any changes to my professional licensure, certification status, and/or employment status of the Program/Agency listed above.

Signature of Billing Provider **Date**

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