First Name:

Authorizing Program Manager Signature:

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:				
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:			
Unlicensed Clinic Licensed Clinic License or Registration	al Staff:		Issue Date:	
NPI #:		Taxonomy #:		
Medcare certified provider, provide PTAN #:			Effective Date:	
COMMENTS (Please p	provide additional information, re	egarding reason	for Modify ARF.)	
PROGRAM CONTAC	T INFORMATION (where com	munication to	program will be sent regarding ARF)	
First Name:		Last Name	e:	
Email:		Phone:		
	al agreement on file with the County o at I have personally reviewed the Coun		as designated by my corporate office, I am autho Policies with the above user.	orizing access as

Rev 10/25/23 Page 1 of 1

Last Name:

Date: