

## Unicare Username Request Form

**Purpose:** This form is used by Mental Health Quality Management (QM) and Drug and Alcohol Quality Improvement (QI) and Information Systems (IS) in completing the Unicare provider file. Accuracy in filling out this form expedites the assigning of the username and provider code number. Please allow 3-5 business days for the completion of this process. Write legibly. Mental Health requestors are to submit 1) Oath of Confidentiality 2) Unicare Username Request Form which must be accompanied by a completed MH PARCCA form (P&P 504) 3) Valid form of identification and 4) Code of Conduct. DADS requestors are to: 1) Oath of Confidentiality and Unicare Username Request Form and other required DADS forms. Incomplete forms will be returned for completion.

For questions in filling out this form and provider code number, please contact IS at 885-5300.

Please fax all appropriate and completed paperwork to your respective QM/QI Department:

MH QM: Phone: (408)793-5894 Fax: (408)288-6113  
 DADS QI: Phone: (408) 792-5670 Fax: (408)947-8707

\*\*\* CONFIDENTIAL PROVIDER INFORMATION \*\*\*

Username: \_\_\_\_\_ SSN: \_\_\_\_\_  
(First Name) (Full Middle Name) (Last Name)  
 Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Job Title: \_\_\_\_\_ UNI/CARE Job Function: \_\_\_\_\_  
 Company/Agency: \_\_\_\_\_  
 Location/Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

A. County  Contract Provider

B. MH  DADS  If not MH or DADS, please specify: \_\_\_\_\_

Requestor's Signature and Date \_\_\_\_\_ Requestor's Printed Name \_\_\_\_\_  
 Requestor's Phone #: \_\_\_\_\_ Requestor's Fax #: \_\_\_\_\_

C. Will an HDX account be needed? Y\_\_\_ N\_\_\_ NPI ID: \_\_\_\_\_

D. For existing UNI/CARE account Updates, specify change request including move and termination notification:  
 \_\_\_\_\_

\*An authorized requestor from all county and contract agencies will be a clinic / program manager, lead clerical supervisor, clerical /billing/finance manager or HR/Administrative Department personnel.

**Information Systems Use Only**

NT Group \_\_\_\_\_ Provider ID: \_\_\_\_\_  
 Provider Type/Tree View/Workflow   
 Screener (Call Center/Gateway)  Other Report  
 Site Clerical  DADS Clerical  Provider granted Override Security  
If DADS clerk (Attach written approval from Paul Hein)  
 Clinical  Administration

Date User was interviewed for network access: \_\_\_\_\_ Interviewed by: \_\_\_\_\_

Date User's connection was checked OK: \_\_\_\_\_ Checked by: \_\_\_\_\_ Checked via: \_\_\_ On- Site \_\_\_ Phone-Call

User's Designated Unicare Access: HHS Direct Connect  HHS T1  DSL/FR  Dial-In  CryptoCard  S\_\_ H\_\_

User's Location Unicare Access: HHS Direct Connect  HHS T1  DSL/FR  Dial-In  CryptoCard  S\_\_ H\_\_

Assigned Username Log-on ID: \_\_\_\_\_ Oath Received: \_\_\_\_\_

Training scheduled on: \_\_\_\_\_ by: \_\_\_\_\_

Fax Sheet to MH / DADS for Notification: Y  N  Analyst: \_\_\_\_\_ Date: \_\_\_\_\_