MACOMB COUNTY COMMUNITY MENTAL HEALTH
ProACT PROVIDER PORTAL USER REQUEST FORM

REQUEST TYPE ☐ **New User Enrollment** ☐ **User Change** ☐ **User Dis-enrollment**

NOTE: All requests for ProAct User access must be submitted by an authorized supervisor

ProAct PORTAL USER ID REQUESTED FOR:

Provider Agency: DRAFT

First Name:	Last Name:
Phone Number:	E-Mail Address:
Job Title:	Date of Hire:

Job Functions: Please place an "X" in one or more boxes as needed.
Administrative ☐ Billing ☐ Clerical ☐ Clinical ☐ Supervisor ☐ Quality ☐ Other ☐

Applicable to CLINICAL STAFF only:

Degree and Date of Graduation (Required):

State of Michigan Professional License(s):

NPI Number (Required for all Licensed staff):

Signature of authorized supervisor: ____ Date: ________________

Title of authorized supervisor: ____

Employee job description submitted: Yes ☐ No ☐

A Supervisory or Administrative staff is responsible for notifying MCCMH immediately if there are circumstances that change an employee's access to ProAct. This includes but is not limited to:

- **Change in employment status: Termination, Temporary Leave, Transfer or Change in Job Functions**
- **Contact information: Change in E-mail Address, Telephone Number or Address of Work Location**
- **Any Changes to a Professional License including: Expiration, Complaints and Disciplinary Action**
- **Name Change**

Authorizing Staff:

____ ____
MCCMH Clinical Strategy Improvement Division Director Clinical Strategy Improvement Division Director designee

For MCCMH Use Only			
Provider Agency Vendor ID:			
New User Notified	Date:	Master User ID Roster Updated:	Date:
User ID Closed	Date:	Master User ID Roster Updated:	Date:
CMT Notified	Date:	Authorized MCCMH Staff:	