User Enrollment Form
(Individual Provider (PSW, DE, IC or BC))

* Indicate Action: ☐ Add ☐ Modify ☐ Deactivate ☐ Name/Login Change	
* User Name: (Last, First MI) *(Print Name)*	* Phone:
* Job Title:	* Provider Name or Number (SPD or eXPRS):
* Address: *(Mailing Address)*	* City, State, Zip:
Already have an eXPRS login name?	* E-mail Address:

INSTRUCTIONS: * Indicates required fields. Send completed form to info.exprs@state.or.us or fax to 503-947-5044.

Add	Del	Role Name	Information within eXPRS
☐	☐	**Provider PSW/DE/IC/BC Claims Manager**	**View:** Claim, Client, Plan of Care, Provider, PSW Menu, Service Authorizations, Service Element **Create, Delete, Submit, Update, View:** Service Delivery **Run:** Report – Client Service Authorization

Print Name	
Signature:	**Date:** / /

Maintain form in local file for audit purposes.