



R3 Limited Access Request Form

Request Type <i>(Check one and enter the effective date)</i>			
	User Addition	Effective Date:	
	User Role Change	Effective Date:	
	User Deletion	Effective Date:	

First & Last Name of User <i>(Print Clearly)</i>			
Employee Work Email			
Employee Phone Number			
Credentials/Degree			
Title/Role			
Agency Name		Agency Address	
Site Name		Site Address	
Supervisor Name			
Supervisor Phone		Supervisor Email	
Permission Type <i>(Check all that apply)</i>	Billing/Claims/EOB <input type="checkbox"/> Yes <input type="checkbox"/> No	SUD Clinical/Intake <input type="checkbox"/> Yes <input type="checkbox"/> No	Will you be submitting an 837/835 EDI transaction? <input type="checkbox"/> Yes <input type="checkbox"/> No

The intent of this request form is to monitor who is accessing consumer information which is protected under HIPAA laws. By utilizing R3, you agree to notify WCMCMH immediately upon termination of an employee with access to this system.

Approval		
Signature of User		Date:
Signature of Supervisor		Date:

**Please submit completed R3 User Access Request Forms to WCMCMH
by email (billing@wmcmmhs.org) or Fax (231-845-7095)**