# Department of Mental Health
# Contract Provider Access Request
**Form** Updated: 4/16/2024

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**Instructions for Completing Form**

**Type of Request**

- New – no previous access requested
- Change – current User ID requires name, level, division or provider change; additional system(s) access; or remove system(s) access
- Revoke – current User ID no longer needs access to DMH systems

**Part 1: Required User Information - MUST BE TYPED - Forms will be returned if illegible or incomplete**

*New Request*

- Complete full name, last four digits of SSN and email address
- Complete provider name, phone number and provider facility code/FTP for the primary provider. If access is needed to additional providers, indicate additional provider facility codes/FTPs.
- Check which division is appropriate for your access

*Change Request*

- Complete full name, last four digits of SSN, email and User ID
- If necessary, complete provider information to be changed.
- Complete division, if changed.
- Note what needs to be changed and/or if dual access is needed.

*Revoke Request*

- Complete full name and User ID of user needing access revoked.

**Part 2: Confidentiality Statement**

- Read the confidentiality statement
- After completing the form, sign where indicated and forward to your Local Security Coordinator.
- The Local Security Coordinator must sign the form and forward it to the appropriate Division. Behavioral Health Providers fax to the Division of DBH. DD providers should fax to Provider Relations or the TAC Office at your Regional Office.
- Please don't use digital signatures as it will prevent the next person in the approval process from signing.

**Part 3:**

To request access to the following applications:

- Mortality Review (DD RESIDENTIAL PROVIDERS ONLY)
- Consumer Referrals (DD RESIDENTIAL OR TCM PROVIDERS ONLY)
- Integrated Quality Management Functions Database (TCM OR SB40'S ONLY)
- CVS (Approved Behavioral Health Providers ONLY)
    - All applications above can now be requested through DARS ONLINE.
    - Under the "Security Access Request" section, select the "DMH Application Request System (DARS) – Non-CIMOR Access" link.
    - Note you will need to have a user id and password in order to access DARS.
    - DARS instructions will be under "Security Access Request" section, labeled "DARS instructions for External Users"

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☐ New User ID ☐ Change Access ☐ Revoke User ID

## PART 1: User Information (MUST BE TYPED)
## *Required Fields must be completed

*Last Name _____ *First Name _____ *MI: _____

*SSN XXX-XX-_____ *Phone _____ User ID (*Required for Change/Revoke) _____

*Email _____

*Title _____

*Provider _____

*Fac. Cd./FTP _____ *City _____

*If change request, list what you want changed _____

**Division:** **Behavioral Health (ADA/CPS)** ☐ **DD TCM Provider** ☐ **DD Service Provider** ☐

## PART 2: Confidentiality Statement

I, the undersigned, a designated representative of the provider named above, understand that the approval and assignment of the requested ID or change request enables me to access the Department of Mental Health information systems. I understand that federal and state laws, require confidentiality of the Department of Mental Health information and provide penalties for unauthorized access, use, or disclosure of this information. I agree to keep confidential all information made available to me through this access. I also agree not to divulge or share my password with anyone.

I agree to use the information obtained through these systems for purposes directly connected with the administration of a federal/state assisted program which provides assistance in cash or in kind, or services, directly to individuals on the basis of need. I agree to access only the information needed to fulfill my job duties associated with working with the Department of Mental Health. I further agree to comply with the policies and procedures established by the Department of Mental Health further governing the access and use of this information.

Violations or disclosures on my part may result in loss of access to the information systems, civil court action, or cancellation of the provider contract with the Missouri Department of Mental Health.

User Signature _____ Date _____

Supervisor Signature _____ Date _____

Local Security Coordinator _____ Date _____

**DMH Central Office Use Only**

Request Completed by _____ Date _____

**Behavioral Health Providers - Fax completed form to: Division of Behavioral Health - 573-526-6033**

***For DD Providers: Fax Completed Form to Provider Relations or TAC at Your Regional Office**

**or Scan Completed Form to your Provider Relations or TAC representative.**

**See Page Three (3) for Regional Office Fax Numbers**

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**REGIONAL OFFICE FAX NUMBERS.**
***(DD PROVIDERS SHOULD FAX DOCUMENTATION TO THEIR APPROPRIATE REGIONAL OFFICE)***

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| **Albany Regional Office**<br>660-771-6198 (Fax) | **Central MO Regional Office**<br>573-817-4255 (Fax) | **Hannibal Regional Office**<br>573-248-2408 (Fax) |
| **Joplin Regional Office**<br>417-629-3026 (Fax) | **Kansas City Regional Office**<br>816-889-3325 (Fax) | **Kirksville Regional Office**<br>660-785-2520 (Fax) |
| **Poplar Bluff Regional Office**<br>573-840-9311 (Fax) | **Rolla Regional Office**<br>573-368-2206 (Fax) | **Sikeston Regional Office**<br>573-472-5308 (Fax) |
| **Springfield Regional Office**<br>417-895-7412 (Fax) | **St. Louis Regional Office**<br>**St. Louis County**<br>314-877-3051 (Fax) | **St. Louis Regional Office**<br>**Tri-County**<br>314-244-8804 (Fax) |