



## Independent Provider

(PSW, Behavior Consultant, Employment/Discovery)

### User Enrollment Form

\* Indicates required fields. Send completed form to: [Info.eXPRS@odhsoha.oregon.gov](mailto:Info.eXPRS@odhsoha.oregon.gov) or fax to 503-947-5044

**Additional form instructions are on the back.**

\*Indicate Action:    **Add User**       **Change of Information**       **Deactivate User**

<p>*<b>User's Name:</b> (Last, First, MI) <i>(Print Name)</i></p>	<p><b>Already have an eXPRS Login?</b>  <input type="checkbox"/> No      <input type="checkbox"/> Yes - Login Name:</p>
<p>*<b>Job Title</b> <i>(*check one):</i></p> <p><input type="checkbox"/> Personal Support Worker (PSW)</p> <p><input type="checkbox"/> Independent Behavior Consultant</p> <p><input type="checkbox"/> Independent Employment/Discovery Provider</p>	<p>*<b>Provider Number(s)</b> <i>(SPD or eXPRS):</i></p>
<p>*<b>User's Address:</b> <i>(Mailing Address)</i></p>	<p>*<b>City, State, Zip:</b></p>
<p>*<b>User's Phone Number:</b></p>	<p>*<b>User's Email:</b></p>

ADD	DEL	User Role/Description
<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Provider PSW Claims Manager</b> – able to <u>Create/Submit/View</u> Service Delivered (SD) billing entries via the eXPRS Desktop and/or eXPRS Mobile-EVV; able to <u>Create/Submit/View</u> PSW Travel Time claims; able to view Service Prior Authorizations (SPAs), provider credential information, claims and payment information; able to print timesheets.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Provider Behavioral Consultant Claims Manager</b> – able to <u>Create/Submit/View</u> Service Delivered (SD) billing entries via the eXPRS Desktop and/or eXPRS Mobile-EVV; able to <u>Create/Submit/View</u> PSW Travel Time claims; able to view Service Prior Authorizations (SPAs) and Service Group information for individuals served, provider credential information, claims and payment information; able to print timesheets.</p>

\***I solemnly swear** *(\*check one):*

I acknowledge that **I also work** as an Agency Direct Support Professional (DSP).

I acknowledge that **I do NOT work** as an Agency Direct Support Professional (DSP).

By signing, I acknowledge that failure to accurately represent my role as a Personal Support Worker or as an Agency Direct Support Professional (DSP) may be considered Medicaid fraud.

<p>*<b>Print User's Name:</b></p>	<p>*<b>Date:</b>                    /      /</p>
<p>*<b>User's Signature:</b></p>	