

HealthWeb[®] User Request Form



Provider Information

Contact Person _____

Practice/Facility Name: _____

Tax Id#: _____

Mailing Address: _____

Phone # _____

Fax # _____

Contact Email Address: _____

Section II

New Users (Additional names may be listed on a separate sheet)

First and Last Name of User	Provider Number (ex: 200000009999)	Password (PHP Use Only)

Section III

Changes/De-Activations

First and Last Name of User	Provider Number (ex: 200000009999)	Type of Change (if you are deleting a user, please note why the login is being disabled)

PHP Use Only

Rcvd from Provider: _____

Requested via IT: _____

Comm. to Provider: _____

Via: email fax

Initials: _____

Please **fax** completed form to:
517-364-8412

If you have questions or need assistance, please contact your Provider Relations Coordinator at 517-364-8312.