NeHII User Access Request Form

Please E-mail completed form to support@nehii.org

Request Date: _____

Action:

☐ **New** ☐ **Cancellation** ☐ **Change** **Effective Date:** _____

Facility/Location:

Employer: _____
Office Address: _____
_____
City: _____
State: _____
Zip Code: _____
Office Telephone: _____
Office Fax: _____

Contact Name: _____
Contact Email: _____

User Information:

First Name: _____
Middle Initial: _____
Last Name: _____
Phone: _____
E-Mail Address: _____
Classification (i.e. MD, DO, RN, PA, etc.)**:** _____
NPI: _____
DEA: _____
State License Number: _____
Specialty (i.e. Neurology, Orthopedics, etc.)**:** _____
Direct Email Address (if applicable)**:** _____
HISP Provider (if applicable)**:** _____
Optum ID (if applicable)**:** _____

Workgroup Administrator Signature: _____