

APS CareConnection® User Termination Form

User's Personal Information

First Name: _____ Last Name: _____

User ID: _____

E-mail Address: _____

Requestor's Phone Number: _____

Please choose the role of the user. Only one role can be requested

Role Type: _____ Delegate
 _____ Direct Service Provider
 _____ Utilization Manager

Agency Information

Agency Name: _____

Medicaid ID: _____

Agency Street Address: _____

City _____ State: _____ Zip Code: _____

Agency Phone Number: _____ Fax: _____

Supervisor Name: _____

Location Information (If Multiple Locations)

All Locations

Location Name: _____ Medicaid ID: _____

Location Name: _____ Medicaid ID: _____

Location Name: _____ Medicaid ID: _____

Signatures

I agree that all information is correct and accurate to the best of my knowledge. By submitting this request, I agree to adhere to all security and privacy requirements when using this system, as mandated by HIPAA.

Requestor Signature: _____ Date: _____

Internal Use Only:

UID: _____ Create Date: _____ Notify Date: _____

APS Employee Name: _____