eXPRS Express Payment & Reporting System

OREGON DEPARTMENT OF Human Services

Independent Provider User Enrollment Form

Send completed form to Info.eXPRS@odhsoha.oregon.gov or fax to (503) 947-5044. An asterisk indicates required fields.

Select Action	
☐ **Add User**	☐ **Change of Information**
☐ **Deactivate User**	

User Information	
*Name: (Last, First MI)	eXPRS Login Name:
*Job Title *(check one)*: ☐ Personal Support Worker ☐ Independent Behavior Consultant ☐ Independent Employment/Discovery Provider	Provider Number(s) (SPD or eXPRS):
*Mailing Address:	*City, State, Zip:
*Phone Number:	*Email Address:

Independent Provider Roles

ADD	DEL	User Role	Description
☐	☐	**Provider PSW Claims Manager**	**Create/Submit:** Service Delivered Billing Entries (Desktop and eXPRS Mobile EVV), PSW Travel Time Claims **View:** Service Prior Authorizations, Service Delivered Billing Entries, Claims, Payment, Provider Credentials **Print:** Timesheets

☐	☐	**Provider Behavioral Consultant Claims Manager**	**Create/Submit:** Service Delivered Billing Entries (Desktop and eXPRS Mobile EVV), PSW Travel Time Claims **View:** Service Prior Authorizations, Service Delivered Billing Entries, Claims, Payment, Provider Credentials, Limited Individual Information **Print:** Timesheets

***I acknowledge** (select one)**:**

☐ That **I also work** as a Direct Support Professional.

☐ That **I do NOT work** as a Direct Support Professional.

*Please Sign Below:

By signing, I affirm all information provided is true and correct, and acknowledge that failure to accurately represent my role as a Personal Support Worker may be considered Medicaid fraud.

Signatures Required	
User's Name:	**Date:**
User's Signature:	