



DME Request for eQSuite® Access

All information must be complete for processing

NOTICE: It is important to notify us immediately when contacts change to ensure effective and timely communications. Check here if this is a request for a change in previously submitted contact information.

Return Completed and Signed Forms
Attention: Provider Outreach
Fax: 855-440-3747
Email: provideroutreach@eqhs.org

Provider Name:			
Mailing Address:			
Provider Medicaid Number:	Provider Type:	NPI:	

Handwritten forms cannot be accepted

Contact Type	Contact Name <small>(First & last name)</small>	Email Address (required)	Telephone Number
System Administrator			

FORM MUST BE SIGNED BY THE ADMINISTRATOR OR CEO

 Administrator or CEO (PLEASE PRINT NAME & TITLE)

Signature: _____

Date: _____