Dental 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 (First & last name)	Email Address (required)	Telephone Number
System Administrator			

FORM MUST BE SIGNED BY THE ADMINISTRATOR OR CEO

Signature: _____

_____

Administrator or CEO (PLEASE PRINT NAME & TITLE)

Date: _____