



## SPP - 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](mailto:provideroutreach@eqhs.org)**

<b>Provider Name:</b>			
<b>Mailing Address:</b>			
<b>Provider Medicaid Number:</b>	<b>Provider Type:</b>	<b>NPI:</b>	

*Handwritten forms cannot be accepted*

Contact Type	Contact Name <small>(First &amp; 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: \_\_\_\_\_