Missouri Consolidated Health Care Plan
573-751-0771 · 800-487-0771 · www.mchcp.org
832 Weathered Rock Court, Jefferson City, MO 65101

eMCHCP Access

Submit this form:
Online: Upload through myMCHCP
Fax: 866-346-8785
Mail: PO Box 104355
Jefferson City, MO 65110-4355

Please print clearly

Instructions

eMCHCP is a secure area within MCHCP's website. eMCHCP provides human resource/payroll representatives with a secure and efficient notification and information system. All information is strictly confidential and should only be used to provide MCHCP with benefit-related information. The agency is responsible for notifying MCHCP of any employment changes or terminations that would change or delete a human resource/payroll representative's access to eMCHCP.

Section 1 – Representative Information

❑ **Add** ❑ **Change** ❑ **Delete**

Name (Last, First, Middle Initial):

MCHCPid (Provide **either** MCHCPid or Social Security Number)
___ ___ ___ ___ ___ – ___ ___ ___ ___ ___

Title:

or **Social Security Number**:
___ ___ ___ – ___ ___ – ___ ___ ___ ___

Department/Agency Name:

Agency Organization Number:

Work Address:

Work Phone Number:
(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

City: **State**: **ZIP Code**:

Work Fax Number:
(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

Work Email:

Attach list or list Agency/Organizations responsibilities below:

Signature:

Date (MM/DD/YYYY):
___ ___ / ___ ___ / ___ ___ ___ ___

Section 2 – FOR ACCESS REQUESTS ONLY

The employee listed above has authority to access confidential employee information on MCHCP's eMCHCP website. I hereby authorize MCHCP to provide access to this human resource/payroll representative.

Department Authorized Representative:

Signature of Department Authorized Representative:

Date (MM/DD/YYYY):
___ ___ / ___ ___ / ___ ___ ___ ___