KEPRO

Provider Registration

Please Type or Print Clearly

Facility Name: ______________________ Agency ID: ______________

Address: ______________________

City: ______________ State: ________ Zip Code: ______________

Phone: Fax: E-mail:

WEB Data Submission Confirmation

The practice will directly enter CareConnection® data via the Web Site to obtain prior authorization of:
(Please check all that apply)

- Adult Inpt.Psychiatric Unit (DRG) ☐
- Inpt. Behavioral Med. Unit (BMU) ☐
- Partial Hospitalization Program ☐
- PRTF ☐
- Inpatient Acute Psych < 21 yrs of age ☐

Provider's Authorized Data Contact

Data Contact: ______________________
First Name Middle Initial Last Name

Mailing Address: ______________________

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Phone: ______________________ Fax: ______________

Data Contact's E-Mail Address: ______________________

Data Contact's Signature ______________________

E-Mail Address for Correspondence

E-Mail Address for Correspondence (Consider the need for correspondence to be received by your practice - you may want to use a common e-mail account or one that you are comfortable sharing with other staff):

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Authorization

Authorization: I authorize the aforementioned Data Contact person to represent our practice regarding Information Services related issues and activities with KEPRO. I understand the Data Contact will receive all Data and Information Services related correspondence and information, be responsible for User maintenance for our practice and interface with KEPRO regarding data and I.S.- related issues.

CEO/Owner: ______________________
First Name Middle Initial Last Name

CEO/Owner: ______________________
Signature

Submit to: KEPRO I.S. 1007 Bullitt St. Charleston, WV 25301 Fax: 866-473-2354