

KEPRO
Provider Registration

Please Type or Print Clearly

Provider/ Practice 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:	
Medically Necessary Services (Medicaid) <input type="checkbox"/>	Socially Necessary Services (BCF) <input type="checkbox"/>

If a Group/Private Practice, list the individual practitioners within the Group (Psychologists and/or Psychiatrists with Individual Medicaid Provider Numbers)			
Individual Practitioner's Name	Psychologist ✓ Check Practitioner Type	Psychiatrist	Individual Medicaid Provider Number
<i>(LBHC's may omit this section)</i>	N/A	N/A	N/A
<i>(LBHC="Licensed Behavioral Health Center")</i>			

Provider's Authorized Data Contact			
Data Contact: _____			
First Name	Middle Initial	Last Name	
Mailing Address: _____			
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): _____

Authorization		
<p>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.</p>		
CEO/Owner: _____	First Name	Middle Initial
		Last Name
CEO/Owner: _____	Signature	