

KEPRO
LICSW - Provider Registration

Please Type or Print Legibly

Provider: _____	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 as a

LICSW

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 that you are comfortable sharing among designated staff or enter additional staff email addresses to ensure your Practice receives and reviews correspondence in a timely manner):

Authorization

I understand the Data Contact and I will receive all correspondence via email. Additionally, the Data Contact will be responsible for approving and requesting deactivation of staff Web User Accounts for your center. Furthermore, I authorize any additional email address (es) in the **Correspondence** section to receive all emails, also.

CEO\Director _____
Email Address
CEO\Director _____
First Name Middle Initial Last Name
CEO\Director _____
Signature

Submit to: KEPRO I.S. 1007 Bullitt St. Charleston, WV 25301 or Fax: 866.473.2354