KEPRO
INTELLIGENT VALUE

WV Nursing Facility and Other PAS Submitters
Provider Registration Form

Facility Information

Please Type or Print Clearly

Facility Name: _____ NPI: _____

Facility Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

WEB Data Submission Confirmation

The practice will directly enter data via the KEPRO Web Site to obtain prior authorization of:

(Please check all that apply)

☐ Nursing Home ☐ Other PAS Submitter

Provider's Authorized Data Contact

Data Contact Name: _____

First Name MI Last Name

Mailing Address: _____

Phone: _____ Fax: _____

Data Contact's Email: _____

Data Contact's Signature: _____

E-Mail Address for KEPRO 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

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

CEO/Owner Name: _____

First Name MI Last Name

CEO/Owner Signature: _____

Signature