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: _____

_____

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

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. 100 Capitol St. Ste. 600 Charleston, WV 25301 Fax: 866-473-2354