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

[X] LICSW

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 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):

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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. 100 Capitol St. Ste. 600 Charleston, WV 25301 or **Fax**: 866.473.2354