

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) <input type="checkbox"/>	Inpt. Behavioral Med. Unit (BMU) <input type="checkbox"/>
Partial Hospitalization Program <input type="checkbox"/>	PRTF <input type="checkbox"/>
Inpatient Acute Psych < 21 yrs of age <input type="checkbox"/>	

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. 1007 Bullitt St. Charleston, WV 25301 Fax: 866-473-2354