

KEPRO

# Applied Behavioral Analysis (ABA) - Provider Registration

Please Type or Print Legibly

|           |       |           |       |
|-----------|-------|-----------|-------|
| Provider: | _____ | Agency ID | _____ |
| Address:  | _____ |           |       |
| City:     | _____ | State:    | _____ |
| 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

|                                     |     |
|-------------------------------------|-----|
| <input checked="" type="checkbox"/> | ABA |
|-------------------------------------|-----|

## 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