APS Healthcare, Inc. - West Virginia

Provider Registration: WV I/DD Waiver Program

Please Type or Print Clearly

Provider Name as Licensed: ____________________ APS Agency ID: __________

Address: ____________________

City: __________ State: ______ Zip Code: __________

Phone: Fax: E-mail:

Select Data Submission Method	**Web Direct Data Entry** ☐	**EDI** ☐

Specify an Administrator who will be authorized to maintain User accounts (e.g. create, deactivate, reset) and review / submit consumer data to APS Healthcare - WV

Provider's Authorized Administrator

Administrator: ____________________

First Name Middle Initial Last Name

Mailing Address: ____________________

____

Phone: __________ Fax: __________

Administrator's E-Mail Address: ____________________

Administrator's Signature ____________________

Provider's Authorized Secondary Administrator (Optional)

Administrator (Secondary): ____________________

First Name Middle Initial Last Name

Mailing Address: ____________________

____

Phone: __________ Fax: __________

E-Mail Address: ____________________

Secondary Administrator's Signature ____________________

Authorization

Authorization: I authorize the aforementioned Administrator(s) to represent our organization relative to our interactions with APS Healthcare, Inc. about the WV I/DD Waiver Program. I understand the Administrator will receive all APS information/correspondence, as well as, be responsible for our organization's Web User maintenance for our practice and interface with APS-WV.

CEO/Owner: ____________________

First Name Middle Initial Last Name

CEO/Owner: ____________________

Signature Date

Submit to: APS-WV I.S. 100 Capitol St. Charleston, WV 25301 Fax: 866-521-6882