

## APS CareConnection® User Access Request Form for Privately Contracted LBHPs

Fax completed form to APS Healthcare at 1-800-762-1639. You will receive your user name and password via email within five business days.

Requestor's Personal Information	
Last Name: _____	
First Name: _____	Middle Init: _____
E-mail Address: _____	
Requestor's Phone Number: _____	
Role Type: Utilization Manager	
Privately Contracted LBHP Provider Information	
Privately Contracted LBHP Provider Name: _____	
Privately Contracted LBHP Individual Provider ID (not NPI): _____	
LBHP Address: _____	
City _____	State: _____ Zip Code: _____
LBHP Phone Number: _____	Fax: _____
Signatures	
I agree that all information is correct and accurate to the best of my knowledge. By submitting this request, I agree to adhere to all security and privacy requirements when using this system, as mandated by HIPAA.	
Requestor Signature: _____	Date: _____
Internal Use Only:	
UID: _____	Create Date: _____ Notify Date: _____
APS Employee Name: _____	