



**MANDATORY**

**APS CareConnection® “Organization” Setup Request Form**

**Organization:**

The APS CareConnection® application is designed to support provider “Organizations” within the Authorization process. An “Organization” in APS CareConnection® acts as an umbrella which allows the Agency/Facility to designate the staff members that will be given access to APS CareConnection® to request authorizations for a specified pool of MaineCare Provider IDs. All users under the umbrella of an “organization” will have access to all of the requests that have been submitted to APS Healthcare by the “Organization”. An Agency/Facility can have more than one “Organization” within APS CareConnection®. The same MaineCare Provider ID can be attached to more than one “Organization”.

You may create as many “organizations” as you need. Please submit a different “Organization” Setup Form for each “organization” you wish to create in CareConnection.

**Please Fax this form to: 1-866-325-4752**

Agency/Facility Information	
Agency/Facility Name:	_____
Address:	_____
City:	_____ State: _____ Zip Code: _____
Phone:	_____ Fax: _____
Authorized Agent Name:	_____
Authorized Agent Phone:	_____
Authorized Agent E-Mail:	_____



**Provider MaineCare Billing ID Information**

**(Include all MaineCare Provider Billing ID numbers for which this “organization” will request authorizations)**

**\* Please remember that you can have more than one “Organization”**

Organization Name: \_\_\_\_\_

*(The “Organization” name should allow the Agency/Facility to easily identify what group of users and services the “Organization” represents)*

MaineCare ID Number: \_\_\_\_\_

MaineCare ID Number: \_\_\_\_\_

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MaineCare ID Number: \_\_\_\_\_

MaineCare ID Number: \_\_\_\_\_

MaineCare ID Number: \_\_\_\_\_

MaineCare ID Number: \_\_\_\_\_

MaineCare ID Number: \_\_\_\_\_

MaineCare ID Number: \_\_\_\_\_

MaineCare ID Number: \_\_\_\_\_

MaineCare ID Number: \_\_\_\_\_



**Authorized Signature**

I agree that all of the 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.

I authorize that this “organization” be established for this Agency/Facility, in APS CareConnection®, as defined on this request form.

**Authorized Agent**

**of the Agency/Facility:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Internal Use Only**

UID: \_\_\_\_\_ Create Date: \_\_\_\_\_ Notify Date: \_\_\_\_\_ Initials \_\_\_\_\_