

ACS ELECTRONIC DATA INTERCHANGE (EDI)



Please Return Form to:
ACS EDI Gateway, Inc.
ATTN: EDI Enrollment Unit
P O Box 4936
Helena, MT 59604
or Fax Form to 1-406-442-4402



Provider ACS EDI Gateway Authorization Form For Billing Agents/Clearinghouses

Section A. Provider Information

Please indicate your classification (**Required**): Individual Provider Group Provider/Practice

Business Name

Provider Name (Last, First, MI and Suffix)

Provider Number (Required for Individuals)

Group Provider Number (Required for Groups)

Business Address

City, State, and Zip

Telephone Number

Fax Number

Contact Name

E-mail Address

Section B. Authorization Signature (**Required**)

Provider, _____ hereby appoints

Provider name /Provider Representative name (please print)

_____,
Billing Agent/Clearinghouse name (please print)

Billing Agent/Clearinghouse ACS Trading Partner/Submitter ID

to act as the authorized agent for the purpose of submitting health care transactions electronically to ACS EDI Gateway, Inc. Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected below:

- 271-Eligibility Response 277-Claims Status Response 278-Prior Authorization Response
 824-Error Report 834-Benefit Enrollment 835-Healthcare Claims Payment Advice

Provider/Provider Representative name (Please print)

Provider/Provider Representative Signature

Date

ACS EDI Gateway, Inc. P O Box 4936 Helena, MT 59604
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