MONTANA DPHHS EDI PROVIDER ENROLLMENT FORM

MONTANA
Department of Public Health & Human Services

**Please return to:**
**ACS, A Xerox Company**
**Attn: MT EDI**
**PO Box 4936**
**Helena, MT 59604**
**Or fax to 406-442-4402**

ACS

## Provider Billing Agent/Clearinghouse ACS EDI Gateway, Inc Authorization Form

| **Section A. Provider Information.** | |
|---|---|
| *Business Name* | |
| *Provider Name (Last, First, MI and Suffix)* | |
| *Provider Number* | *Federal Tax ID Number* |
| *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:**

- ☐ 277-Claim Status Response
- ☐ 835-Healthcare Claims Payment Advice
- ☐ Exception Report (Print Image)
- ☐ 277CA-Healthcare Claim Acknowledgement
- ☐ 271-Eligibility Response
- ☐ 278-Prior Authorization Response
- ☐ 999-Implementation Acknowledgement

_____
*Provider/Provider Representative name (Please print)*

_____ _____
*Provider/Provider Representative Signature* *Date*