

MONTANA DPHHS EDI 835 REQUEST FORM



Please return to:
Conduent EDI Solutions, Inc.
Attn: MT EDI
PO Box 4936
Helena, MT 59604
Or fax to 406-442-4402



Provider Billing Agent/Clearinghouse Conduent EDI Solutions, Inc Authorization Form

Section A. Provider Information.

Form with fields: 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 Conduent Trading Partner/Submitter ID

to act as the authorized agent for the purpose of submitting health care transactions electronically to Conduent EDI Solutions, 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