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*