

MARYLAND PMHS
 ACS EDI TRADING PARTNER ENROLLMENT FORM
 FOR SUBMITTERS
 Software Vendor/Clearinghouse/Billing Agent



A1. TRADING PARTNER TYPE <i>(Please select the type of Trading Partner you wish to become with ACS EDI Gateway, Inc.)</i>										
<i>Please select all that apply</i>										
<input type="checkbox"/> SOFTWARE VENDOR <i>(I plan to develop, test, and distribute my own software package to my provider clients. Once testing is complete, my clients will use this software to submit production transactions directly to ACS EDI Gateway.)</i>										
<input type="checkbox"/> CLEARINGHOUSE/ <i>(I plan to test and submit production transactions directly to ACS EDI Gateway on behalf of my provider clients.)</i>										
<input type="checkbox"/> BILLING AGENT <i>(I plan to test and submit production transactions directly to ACS EDI Gateway on behalf of my provider clients.)</i>										
<p>Note to Billing Agents and Clearinghouses (Software vendors are not included): Because you plan to transmit on behalf of your provider clients, each of your provider clients must complete form C (<u>Provider Authorization form for Billing Agent/Clearinghouse</u>) of this packet. This information is needed to maintain a stable transmission environment and an accurate provider/agent relationship within our systems.</p>										
A2. SUBMITTER INFORMATION										
Business Name										
Business Street Address										
City, State, Zip Code										
Provider Number (if applicable)	Telephone	Fax								
Email Address (If applicable)										
If you are currently enrolled with ACS EDI Gateway, please indicate your ACS EDI Gateway Trading Partner ID: A Trading Partner ID could range between 3-8 digits.		<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>								
Contact Individual										
Contact Name <i>and Title</i>										
Business Street Address										
City, State, Zip Code										
Telephone	Fax									
Email Address (If applicable)										
Additional Contact Individual										
Contact Name <i>and Title</i>										
Business Street Address										
City, State, Zip Code										
Telephone	Fax									
Email Address (If applicable)										

Please return completed form to:
 ACS EDI
 Attn: Technical Support/Enrollment
 P.O. Box 34734
 Washington DC 20043-4761

Please allow 7 to 10 processing days

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A3. SUBMISSION SOFTWARE

What software will you use to submit your electronic transactions? (Check all that apply)

- I will submit using the WINASAP2003 software (*Modem to Modem Dial-up, Direct Submission to ACS EDI Gateway, Inc*)
 You may download a **free** copy of the WINASAP2003 software from our web site at www.acs-gcro.com
- I will submit using a vendor-supplied software (*Please also complete Form B of this packet*)
- I plan to develop my own software package. (*List your software product name, version, and protocol below*)

<i>Software Product Name</i>	<i>Version</i>	<i>Protocol</i>
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A4. X12N TRANSACTIONS AND RESPONSES

Please check each transaction and response you plan to submit and/or retrieve.

<u>SUBMIT</u> TRANSACTIONS	<u>RETRIEVE</u> TRANSACTION RESPONSES
<input type="checkbox"/> Institutional Claim X12N 837I <input type="checkbox"/> Professional Claim X12N 837P	<input type="checkbox"/> Claim Payment/Advice X12N 835 <input type="checkbox"/> Error Report X12N 824

Please select a transaction response Retrieval Method

<input type="checkbox"/> BBS (ACS Bulletin Board System) <i>modem dial up</i>	<input type="checkbox"/> IDEx (ACS Internet Data Exchange)
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FORM B

Any Billing Agent or Clearinghouse using the services of a software vendor should complete this form.

*Please provide the following information concerning your software vendor
 Failure to provide this information will lead to a delay in processing your enrollment request.*

3 Very Important Things to Remember:

- Your Software Vendor must enroll with ACS EDI Gateway, Inc.
- Your Software Vendor must receive an ACS EDI Gateway, Inc Trading Partner ID/Logon/Password
- Your Software Vendor must test with ACS EDI Gateway, Inc.

B1. Software Vendor Information

<i>Software Vendor Company Name</i>										
<i>Software Product Name</i>	<i>Software Version</i>	<i>Software Protocol</i>								
<i>Contact Name</i>	<i>Contact Title</i>									
<i>Business Address</i>										
<i>City, State, and Zip Code</i>										
<i>Telephone</i>	<i>Fax</i>									
<i>Email Address</i>										
<i>Please indicate your Software Vendor's ACS EDI Gateway, Inc. Trading Partner ID: Please contact your software vendor to obtain this information.</i>		<table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> <p style="text-align: center;"><i>Required</i></p>								

Your Provider Name: _____

Your Provider Number: _____

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FORM C



Provider Authorization Form for Billing Agent/Clearinghouse

Any provider wishing to authorize an agent to transmit on their behalf must complete this form.

Section A. Provider Information	
<i>Business/Provider Name (Last, First, MI and Suffix)</i>	
<i>Business Address</i>	
<i>City, State, and Zip</i>	
<i>Provider Number (Required)</i>	<i>Contact Individual</i>
<i>Telephone Number</i>	<i>Fax Number</i>
<i>E-mail Address</i>	
Section B. Authorization Signature	

Provider, _____ hereby appoints
Provider name /Provider Representative name (please print)

_____, _____
Billing Agent/Clearinghouse name (please print) *Billing Agent/Clearinghouse ACS Trading Partner ID*

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

X12N 835 (Healthcare Claim Payment Advice)

Provider/Provider Representative Name (Please print)

Provider/Provider Representative Signature *Date*