

ACS EDI Gateway, Inc. Pharmacy ACS Authorization Form for Washington, D.C.



Please return to:  
ACS EDI  
Attn: Technical Support/Enrollment  
PO Box 34734  
Washington DC 20043-4761  
Or fax to: 202-906-8399



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

**Section A. Provider Information.**

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

*Business Person*

*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 retrieving health care responses electronically from ACS EDI Gateway, Inc.

835-Healthcare Claims Payment Advice

\_\_\_\_\_  
*Provider/Provider Representative name (Please print)*

\_\_\_\_\_  
*Provider/Provider Representative Signature*

\_\_\_\_\_  
*Date*