

Washington, D.C. WINASAP2003 Registration Form



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



**WINASAP2003 REGISTRATION FORM.**

Please print or type. Complete all areas of the WINASAP2003 Registration Form, unless otherwise indicated.

**Section 1. Classification.** Please indicate your classification.

Provider       Billing Agent       Clearinghouse

**Section 2. Submitter Information.**

*Business Name (If applicable)*

*Submitter Name (Last, First, MI, and Suffix)*

*Business Street Address*

*City, State, and Zip Code*

*Telephone*

*Fax*

*Email Address*

**Section 3. Submitter ID Number.**

If you are currently submitting electronic transactions directly to ACS EDI Gateway, please indicate your ACS EDI Gateway 5-digit Submitter ID:

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**Section 4. Contact Information.** Please indicate contact information.

<i>Contact Person</i>	<i>Contact Title</i>
<i>Business Street Address</i>	
<i>City, State, and Zip Code</i>	
<i>Telephone</i>	<i>Fax</i>
<i>Email Address</i>	

**Additional Contact Information.** Please indicate additional contact information.

<i>Contact Person</i>	<i>Contact Title</i>
<i>Business Street Address</i>	
<i>City, State, and Zip Code</i>	
<i>Telephone</i>	<i>Fax</i>
<i>Email Address</i>	

Please attach additional sheets if necessary.

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**Section 5. Electronic Response Retrieval.**

Washington, D.C. WINASAP2003 can retrieve their electronic responses from the ACS EDI Gateway Internet Data Exchange (iDEx). If you would like to participate in this service, please complete the section below. For more detailed information regarding electronic remittance advices, please see the 835 Companion Guide located on the ACS EDI Gateway website at [www.acs-gcro.com](http://www.acs-gcro.com).

*Responses Available for X12N Transactions.*

<input type="checkbox"/> X12N 997 (Functional Acknowledgement)	<input type="checkbox"/> X12N 835 (Healthcare Claim Payment/Advice)
<input type="checkbox"/> X12N 271 (Eligibility Response)	<input type="checkbox"/> X12N 277 (Claims Status Response)
<input type="checkbox"/> X12N 278 (Prior Authorization Response)	<input type="checkbox"/> X12N 824 (Error Response)

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

**Section A. Provider Information.**

Please indicate your classification ( <b>required</b> ):    ρ Individual Provider    ρ Group Provider/Practice	
Business Name	
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 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:

- ρ 997-Functional Acknowledgement
- ρ 824-Error Report
- ρ 277-Claims Status Response
- ρ 278-Prior Authorization Response
- ρ 271-Eligibility Response
- ρ 835-Healthcare Claims Payment Advice

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

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

\_\_\_\_\_  
Date