

ACS EDI Gateway WINSASAP Authorization Form for Washington, D.C.



Please return to:
ACS
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):		<input type="checkbox"/> Individual Provider	<input type="checkbox"/> Group Provider/Practice
<i>Business Person</i>			
<i>Provider Name (Last, First, MI and Suffix)</i>			
<i>Provider Number (Required for Individuals)</i>		<i>Group Provider Number (Required for Groups)</i>	
<i>Business Address</i>			
<i>City, State, and Zip</i>			
<i>Telephone Number</i>		<i>Fax Number</i>	
<i>Contact Name</i>		<i>E-mail Address</i>	

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.

- | | | |
|---|---|---|
| <input type="checkbox"/> 277-Claims Status Response | <input type="checkbox"/> 271-Eligibility Response | <input type="checkbox"/> 824-Error Report |
| <input type="checkbox"/> 835-Healthcare Claims Payment Advice | <input type="checkbox"/> 278-Prior Authorization Response | <input type="checkbox"/> 997-Functional Acknowledgement |

Provider/Provider Representative name (Please print)

Provider/Provider Representative Signature

Date