ACS ELECTRONIC DATA INTERCHANGE (EDI)

Please Return Form to:
ACS EDI Gateway, Inc.
ATTN: EDI Enrollment Unit
P O Box 4936
Helena, MT 59604
or Fax Form to 1-406-442-4402

Provider ACS EDI Gateway Authorization Form For Billing Agents/Clearinghouses

Section A. Provider Information

Please indicate your classification (***Required***): ☐ Individual Provider ☐ 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)

PracticePRO Software Systems Inc., 8066205
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:

☐ 271-Eligibility Response ☐ 277-Claims Status Response ☐ 278-Prior Authorization Response
☐ 824-Error Report ☐ 834-Benefit Enrollment ☐ 835-Healthcare Claims Payment Advice

_____
Provider/Provider Representative name (Please print)

_____ _____
Provider/Provider Representative Signature *Date*