



Pay-To Election

I am enrolled as an individual provider (e.g., physician, ANP, dentist, therapist). I am also associated with one or more group practices. I understand that if I am a sole practitioner, payment for my services can be made to me. If I am a member of a group practice, payment for my services should be made to the group practice.

Please initial ONE of the following:

- Some of the claims submitted for services I render will be paid to the group practice(s) with which I am associated. I also intend to submit claims that will be paid directly to me and reported to the IRS under my SSN or EIN.
- All of the claims submitted for services I render will be paid to the group practice(s) with which I am associated. I do NOT intend to submit any claims that will be paid directly to me and reported to the IRS under my SSN or EIN. I authorize Alaska Medical Assistance to direct all payments for my services to the group provider ID indicated on claims submitted.
- I previously authorized Alaska Medical Assistance to direct all payments for my services to the group provider(s) with which I am associated. I now intend to also submit claims that will be paid directly to me and reported to the IRS under my SSN or EIN.

_____ Provider Name (please print)

_____ Individual NPI

_____ Individual Medicaid Contract ID

Provider Signature

Date

Please return this form with an original signature to:

ACS Provider Enrollment
P.O. Box 240808
Anchorage, Alaska 99524-0808

This form may be used only for specifying your Pay-To Election. To make any additional changes, including address, group affiliation, etc., please use the Change of Medicaid Provider Information form available at:
http://medicaidalaska.com/Downloads/Providers/AK_Provider_Change_Info.pdf