

## Provider Electronic Remittance (835) Authorization

Alaska Medical Assistance is capable of sending an 835 transaction to a single entity/organization only. The purpose of this form is to allow providers to designate who should receive their 835. Please complete the following form for this designation and indicate all State Provider Identification Number(s) and corresponding National Provider Identifier (NPI) number(s) that are applicable.

**Send My 835 To:**

Self (practice management software able to receive)

Billing Agent

Clearinghouse

Other

**Organization Name:** \_\_\_\_\_

**Contact Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Provider Name:** \_\_\_\_\_

<b>State Provider Identification Number</b> _____	<b>Corresponding NPI#</b> _____
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<b>State Provider Identification Number</b> _____	<b>Corresponding NPI#</b> _____

**Telephone #:** \_\_\_\_\_

Attach additional pages if necessary

I authorize the above named entity to receive and process my electronic remittances (835) from Alaska Medical Assistance Programs. I may have multiple entities submitting claims for me and understand that only one entity can be designated by me to accept and process my electronic remittance. I also understand that the entity I have authorized above must have prior approval from Affiliated Computer Services, Inc. to receive electronic remittances.

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**Print Authorized Representative Name**

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**Title Authorized Representative**

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**Signature of Provider\* or Authorized Representative\*\***

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**Date**

\* *Individuals and sole proprietors must sign their own enrollment agreement form.*

\*\* *An authorized representative is an appointed official to whom the provider has granted the legal authority to enroll the provider in the Medicaid program, to make changes and/or updates to the provider's status in the Medicaid program (e.g., new practice locations, changes of address, etc.), and to commit the provider to fully abide by the laws, regulations, and program instructions of the Medicaid program. The authorized official must be the provider's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the provider's organization, or must hold a position of similar status and authority within the provider's organization.*

*If you fax this document, please be sure to mail the original.*

**Mail original or fax to:**      **Affiliated Computer Services, Inc.  
HIPAA Provider Support Team  
P.O. Box 240808  
Anchorage, AK 99524-0808**

**Fax number: (907) 644-8126**