



ACS is now a Xerox company

**ATTACHMENT FAX COVER SHEET**  
**P.O. Box 240808 • ANCHORAGE, ALASKA 99524-0808**  
**TELEPHONE: (907) 644-6800 or (800)770-5650**  
**FAX (907) 644-8122/(907) 644-8123**

To: \_\_\_\_\_ Date: \_\_\_\_\_

From: \_\_\_\_\_ Fax#: \_\_\_\_\_

Number of Pages: \_\_\_\_\_ Time: \_\_\_\_\_

Submitter Number: \_\_\_\_\_ MCN #: \_\_\_\_\_

Submission Date: \_\_\_\_\_ Provider #: \_\_\_\_\_

Indicate the Transaction Type:

- 837P (Professional)       837I (Institutional)       837D (Dental)
- Transportation/Accommodation or Other Noncovered Entity  
(Include the recipient ID number on each page faxed)

Unique Attachment Control Number(s):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Note: Include the appropriate Attachment Control Number on each faxed page.

**CONFIDENTIALITY NOTICE**

This message, including any attachments, is intended solely for the use of the named recipient(s) and may contain confidential and/or privileged information. Any unauthorized review, use, disclosure, or distribution of this communication is expressly prohibited. If you are not the intended recipient, please notify the sender at the sender's fax number above and destroy any and all copies of the original message. Thank you.

Rev.05/25/2010



**STATE OF ALASKA**  
**Department of Health and Social Services**  
**PROVIDER INFORMATION SUBMISSION AGREEMENT**

The following constitutes an Information Submission Agreement between a provider enrolled in the Alaska Department of Health and Social Services Medical Assistance Program (“*Provider*”), and the State of Alaska, Department of Health and Social Services (“*State*”). The terms of this agreement govern the submission of clinical and financial information sent to the State in support of services performed by the Provider.

I, \_\_\_\_\_, as Provider, enter into this Provider Information Submission Agreement with the State as authorization to submit clinical and financial information directly to the State either: (1) electronically by me; or (2) in an electronic or paper format through a Billing Agent on my behalf. All information submitted under the terms of this agreement is in support of services performed by me.

Section I. Terms of Agreement ( <i>To be completed by the “Provider”</i> )	
1.	I am the Provider named above
2.	I agree to comply with all state and federal laws as they apply to the State of Alaska, Department of Health and Social Services programs in which I participate.
3.	I agree that payment and satisfaction of claims that I submit or that are submitted by my Billing Agent, including electronic transactions, will be from federal and state funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable federal or state laws.
4.	I agree that I am fully responsible for all information and claims submitted by my Billing Agent or me and that all overpayments made to me by the State will be repaid by me.
5.	I agree to comply with the current and future Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) for all services, information, and transactions, including electronic transactions, privacy, and security regulations.
6.	I agree that any transactions completed under this agreement will be compliant with all state and federal laws, including Title VII of the Civil Rights Act of 1964, which prohibits exclusion or discrimination on the basis of race, color, religion, sex, or national origin.
7.	I agree to test any changes or modifications to my electronic file or file layout or my Billing Agent’s electronic file or file layout and seek approval of my test submission by the State. I understand that failure to do so may result in claim processing delays.
8.	I agree to provide the State 30 days notice to set up or change electronic file or file layout specifications for information submissions. I agree to cooperate by transmitting test transactions to the State during a set-up period prior to any transmission to the State. I understand that the duration of testing may be 30 days or more.
9.	I agree, as applicable, to submit Alaska-specific data elements in accordance with State of Alaska Medical Assistance Provider Billing Manuals, Companion Guides, and other State Program Guides to the extent that Alaska-specific data elements do not change the meaning or intent of any of the Health and Human Services (HHS) Transaction Standard’s implementation specifications (45 CFR Part 162.915(d)) and/or do not change any definition, data condition or use of a data element or segment as proscribed in the HHS Transaction Standard Regulation. (45 CFR Part 162.915(a)).



20. Software Vendor Information: (Complete this item only if box 19a is checked)		
Vendor Name	Telephone number	Fax Number
Vendor Address	City	State <span style="float: right;">Zip+4</span>
Vendor Contact Name	Contact Telephone Number	Contact E-Mail Address (if available)
21. Billing Agent Information: I authorize the following Billing Agent to submit information, including claims, on my behalf (Complete this item ONLY if you will be billing indirectly through a Billing Agent, Clearinghouse, contractor, or other entity):		
Billing Agent's Business Name	Billing Agent's Telephone Number	Billing Agent's Fax Number
Billing Agent's Mailing Address	City	State <span style="float: right;">Zip+4</span>
Billing Agent's Physical Address	City	State <span style="float: right;">Zip+4</span>
Billing Agent's Contact Name	Contact's Telephone Number	Contact's E-Mail Address (if applicable)
22. Contact Person's Information: This section is to be completed with the name(s) and telephone number(s) of the individual(s), other than yourself or the billing agent listed above, who can answer questions about the information furnished in this Information Submission Agreement. You do not need to furnish any names if you want all questions directed to you. Check here <input type="checkbox"/> if you want all questions directed to you.		
Contact Name	Contact Telephone number	Contact Fax Number
Contact Address	City	State <span style="float: right;">Zip+4</span>
Contact E-Mail Address		
23. <b>I understand and agree to comply with all items numbered 1-22 listed above. By my signature below, I acknowledge my responsibility for compliance with this agreement and my authority to enter into this agreement on behalf of the Provider. Additionally, by my signature below, I, the Provider, authorize the Billing Agent named above to submit information, including claims, on my behalf. No photocopies or facsimile signatures will be accepted.</b>		
Provider Business Name (print)	State Provider Identification Number (Only one ID per Agreement see instructions)	
Provider's Name* or Authorized Representative's Name**	Title as applicable (print)	
Signature of Provider* or Authorized Representative**	Date of Signature	

\* 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.

**Section II. Definitions**

“Billing Agent” used in this agreement means: Any Billing Agent, Clearinghouse, billing service, other third party submitter, contractors, or other entity submitting information directly to the Alaska Medical Assistance Program, State of Alaska, Department of Health and Social Services, on behalf of an enrolled Provider.

“Provider” used in this agreement means: A party who is properly enrolled in the State of Alaska Department of Health and Social Services program(s) including, as applicable, the Alaska Medical Assistance Program, and authorized to provide and be reimbursed for covered services.

“State” used in this agreement means: The State of Alaska, Department of Health and Social Services, or its designee.

**Section III. To Be Completed by the State or its Designee**

The State agrees to continue to mail checks, remittance advices, resubmission turnaround documents etc., directly to the Provider, Provider’s Billing Agent, or other entity as recorded on the State’s Medicaid Management Information System (MMIS) provider and submitter files. The State agrees to comply with all HIPAA laws.

- This agreement is effective and begins on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_. The above Provider is authorized to submit information, which may include claims, to the State.
- This agreement is effective and begins on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_. The above Provider has authorized the Billing Agent identified above to submit information, which may include claims, to the State on the Provider’s behalf.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
State Representative or designee Name, Title, and (if applicable, designee’s Company or Agency Name)

\_\_\_\_\_  
State or State’s designee Signature

\_\_\_\_\_  
Date of Signature

**Section IV. To Be Completed by the State or its Designee**

	Begin date	End date
Test Submitter # assigned to this Provider _____	_____	_____
Production Submitter # assigned to this Provider _____	_____	_____
Termination effective date: _____ Date termination notification received: _____		
Hard copy file updated _____	MMIS file updated: _____	_____
_____	_____	_____
_____	_____	_____
Electronic submitter file updated: _____	_____	_____



**STATE OF ALASKA**  
**Department of Health and Social Services**  
**INSTRUCTIONS TO PROVIDER FOR COMPLETING**  
**THE PROVIDER INFORMATION SUBMISSION AGREEMENT**

1. In the blank at the top of the form, fill in the provider's business name:

I, \_\_\_\_\_, as Provider, enter into this Provider Information Submission Agreement with the State as authorization to submit clinical and financial information directly to the State either: (1) electronically by me; or (2) in an electronic or paper format through a Billing Agent on my behalf. All information submitted under the terms of this agreement is in support of service performed by me.

2. ***Section I – Terms of Agreement***

Section I, items #1 through #15 – These items are statements that a provider agrees to when the Information Submission Agreement is signed. Please read all items carefully.

Section I, item #16 – Check the appropriate box. Regardless of whether you will be submitting information directly from your office, or authorizing submission by another entity, please indicate if the information will be HIPAA compliant or not.

Section I, item #17

a. Check the appropriate box. Indicate whether *claims* information submitted to Alaska Medical Assistance will be in paper or electronic format. If you are using a separate entity (billing agent, clearinghouse, etc.) to submit claims transactions, check the box indicating the format that the separate entity will be using.

b. Check the appropriate box. Indicate whether other information (see list in #18) submitted to Alaska Medical Assistance will be in paper or electronic format.

Section I, item #18 – Check all boxes that apply or will apply within the next year. *If you do not plan to submit HIPAA-compliant transactions, check the last box, “N/A (Not Applicable).”*

Section I, item #19 – Check the appropriate box.

a. If you will be sending your information directly from your practice management software to Alaska Medical Assistance, check the first box (*office system*).

b. If you will be using *Payerpath*<sup>SM</sup> directly, or if you will be using a separate entity to submit information that will ultimately reach Alaska Medical Assistance through *Payerpath*<sup>SM</sup>, check the 2<sup>nd</sup> box (*Payerpath*<sup>SM</sup>).

c. If you are a pharmacy provider and use the Point of Sale (POS) system, check the 3<sup>rd</sup> box (*Point of Sale*).

d. If you will be using a billing agent, clearinghouse, contractor, or other third-party entity, check the 4<sup>th</sup> box (*Billing Agent or Clearinghouse*).

Section I, item #20 – If you will be using HIPAA-compliant software, fill in the requested information about your software vendor. If there are any technical problems with information submission, we may use the information you provide to contact the vendor.

Section I, item #21 – This section is your authorization for another party to submit information on your behalf. You only need to complete this section if you will be using a Billing Agent/Clearinghouse/contractor or other entity to submit your information. You only need to provide information about the entity submitting *directly* to Alaska Medical Assistance. You do not need to provide any information about other companies that may handle your information between you and the final Billing Agent/Clearinghouse/contractor.

Section I, item #22 – This item asks for contact information. Please provide the requested information for someone who can discuss your Information Submission Agreement or submitted information with Affiliated Computer Services, Inc. (ACS) or the State of Alaska. If you do not want ACS or the State of Alaska communicating with anyone but yourself, check the box provided.

Section I, item #23 – **This item must be completed for the Information Submission Agreement to be valid.**

The “Provider Business Name” field should contain the provider’s pay-to business legal name. This name must match the business name provided to the IRS.

The “State Provider Identification Number (only one ID per Agreement)” field should contain one State Provider Identification Number only. If you are a provider who practices individually *and* as a member of a group, you should fill out an agreement for your individual practice. A group practice authorized representative will fill out a separate agreement for the group. If you have more than one location, you will need to fill out an agreement for each location.

The “Provider’s Name or Authorized Representative’s Name,” “Signature of Provider or Authorized Representative,” and “Title as applicable (print)” fields should contain an individual’s name and title. If the provider’s business is a sole proprietorship or owned by an individual, the individual owner/proprietor must sign and date the agreement. If an authorized representative is signing and dating the agreement, that representative must be a 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.

**3. Sections III, IV** –Do not complete. These sections are reserved for the State of Alaska and Affiliated Computer Services.



**STATE OF ALASKA**  
**Department of Health and Social Services**  
**BILLING AGENT INFORMATION SUBMISSION AGREEMENT**

The following constitutes an Information Submission Agreement between a Billing Agent, Clearing House, or other entity (“Billing Agent”) and the State of Alaska, Department of Health and Social Services (“State”). The terms of this agreement govern the submission, by the Billing Agent, of the Provider’s clinical and financial information sent in support of services performed by the Provider.

I, \_\_\_\_\_, as Billing Agent, enter into this Billing Agent Information Submission Agreement with the State as authorization to submit, in either electronic or paper format, the Provider’s clinical and financial information directly to the State on behalf of the Provider. All information submitted under the terms of this agreement is in support of services performed by the Provider.

Section I. Terms of Agreement ( <i>To be completed by the “Billing Agent”</i> )
1. I am the Billing Agent named above.
2. I agree to comply with all state and federal laws as they apply to the State of Alaska, Department of Health and Social Services programs in which I participate.
3. I agree that payment and satisfaction of claims that I submit, including electronic transactions, will be from federal and state funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable federal or state laws.
4. I agree to comply with the current and future Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) for all services, information, and transactions, including electronic transactions, privacy, and security regulations.
5. I agree that any transactions completed under this agreement will be compliant with all state and federal laws, including Title VII of the Civil Rights Act of 1964, which prohibits exclusion or discrimination on the basis of race, color, religion, sex, or national origin.
6. I agree to test any changes or modifications to my electronic file or file layout and seek approval of my test submission by the State. I understand that failure to do so may result in claim processing delays.
7. I agree to provide the State 30 days notice to set up or change electronic file or file layout specifications for information submissions. I agree to cooperate by transmitting test transactions to the State during a set-up period prior to any transmission to the State. I understand that the duration of testing may be 30 days or more.
8. I agree, as applicable, to submit Alaska-specific data elements in accordance with State of Alaska Medical Assistance Provider Billing Manuals, Companion Guides, and other State Program Guides to the extent that Alaska-specific data elements do not change the meaning or intent of any of the Health and Human Services (HHS) Transaction Standard’s implementation specifications (45 CFR Part 162.915(d)) and/or do not change any definition, data condition or use of a data element or segment as proscribed in the HHS Transaction Standard Regulation. (45 CFR Part 162.915(a)).
9. I agree that I have the responsibility to ensure that all information is complete and accurate, and that all electronic transactions meet the standards for HIPAA compliance.

Section I. Terms of Agreement, continued (To be completed by the "Billing Agent")

10. I agree to comply with audit rules as required by state and federal law by providing access to and review of my records and the records I maintain on behalf of the Provider.

11. I agree to comply with state and federal records retention laws that govern records maintained by me on behalf of the Provider.

12. I agree to protect my assigned State identification numbers (including submitter numbers) and State passwords against unauthorized use.

13. I agree to terminate this agreement immediately if I no longer have any active Department of Health and Social Services Provider clients for whom I actively submit information or claims. I will terminate this agreement by making written notification to the State.

14. I plan to submit the following:  
 Non-HIPAA-Compliant Information       HIPAA-Compliant Information

15. (a) I will be sending claims in the following format:  
 Paper       Electronic  
(b) I will be sending other information in the following format:  
 Paper       Electronic

16. I will be sending claims and other information:  
a.  Directly from my *Billing Agent office system* to the State  
b.  Through *Point of Sale* to the State

17. I intend to submit the following types of transactions:  
 Eligibility Request/Response (270/271)  
 Claims Status Request/Response (276/277)  
 Prior Authorization Request/Response (278/278)  
 Remittance Advice (835)  
 Dental (837 D)  
 Institutional (837 I)  
 Professional (837 P)  
 Pharmacy (NCPDP- batch)  
 N/A (Not Applicable)

Section I. Terms of Agreement, continued (To be completed by the "Billing Agent")

18. Software vendor information: (Complete only if 16a is checked)

\_\_\_\_\_  
Vendor Name

\_\_\_\_\_  
Vendor Address

\_\_\_\_\_  
Vendor Contact Name

\_\_\_\_\_  
Vendor Contact Telephone Number

\_\_\_\_\_  
Vendor Main Telephone Number

\_\_\_\_\_  
Vendor E-Mail Address (if available)

\_\_\_\_\_  
Vendor Fax Number

19. By my signature below, I attest that

- (a) I have been authorized by properly enrolled Provider(s) in the State of Alaska, Department of Health and Social Services program, to submit information, including claims, on behalf of that (those) Provider(s) to the State; and
- (b) I will only submit information, including claims, on behalf of the provider(s) from whom I have legal authorization to do so.
- (c) I agree to notify the State, by the close of business on the next working day for the State of Alaska, if for any reason I revoke or terminate any agreement with the above Provider(s).
- (d) I agree to notify the State of any change to my Billing Agent address, telephone, or other required information within three (3) working days.

20. I agree to comply with all items numbered 1-19 listed above. By my signature below, I acknowledge my responsibility for compliance with this agreement and my authority to enter into this agreement on behalf of the Billing Agent.

\_\_\_\_\_  
Provider Business Name (print)      State Provider Identification Number      NPI(s)  
(List on Back if more space is needed)      (List on Back if more space is needed)      (List on Back if more space is needed)

\_\_\_\_\_  
Billing Agent's Business Name

\_\_\_\_\_  
Billing Agent's Mailing Address

\_\_\_\_\_  
Billing Agent's Physical Address

\_\_\_\_\_  
Billing Agent's Contact Name

\_\_\_\_\_  
Billing Agent's Contact Telephone Number

\_\_\_\_\_  
Billing Agent's Main Telephone Number

\_\_\_\_\_  
Billing Agent's E-Mail Address

Section I. Terms of Agreement, continued *(To be completed by the "Billing Agent")* Signature Required. (No photocopies or facsimile signatures will be accepted.)

\_\_\_\_\_  
Billing Agent's Fax Number

\_\_\_\_\_  
Billing Agent's Authorized Representative\* Name and Title

\_\_\_\_\_  
Signature of Billing Agent's Authorized Representative\*

\_\_\_\_\_  
Date

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

Section II. Definitions

“Billing Agent” used in this agreement means: Any Billing Agent, Clearinghouse, billing service, other third party submitter, contractors, or other entity submitting information directly to the Alaska Medical Assistance Program, State of Alaska, Department of Health and Social Services on behalf of an enrolled Provider.

“Provider” used in this agreement means: A party who is properly enrolled in the State of Alaska Department of Health and Social Services program(s) including as applicable, the Alaska Medical Assistance Program, and authorized to provide and be reimbursed for covered services.

“State” used in this agreement means: The State of Alaska, Department of Health and Social Services or its designee.

Section III. To Be Completed by the State or its Designee

The State agrees to continue to mail checks, remittance advices, resubmission turnaround documents etc., directly to the Provider, Provider’s Billing Agent, or other entity as recorded on the State’s Medicaid Management Information System (MMIS) provider and submitter files. The State agrees to comply with all HIPAA laws.

This agreement is effective and begins on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_. The above Billing Agent is authorized to submit information, which may include claims, to the State on behalf of the above listed Provider(s).

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
State Representative or designee Name, Title, and (if applicable designee’s Company or Agency Name)

\_\_\_\_\_  
State or State’s designee Signature

\_\_\_\_\_  
Date of Signature

Section IV. To Be Completed by the State or its Designee

	Begin date	End date
<b>Test</b> Submitter # assigned to this Billing Agent _____	_____	_____
<b>Production</b> Submitter # assigned to this Billing Agent _____	_____	_____

Termination effective date: \_\_\_\_\_ Date termination notification received: \_\_\_\_\_

Hard copy file updated \_\_\_\_\_

MMIS file updated: \_\_\_\_\_

Electronic submitter file updated: \_\_\_\_\_



**STATE OF ALASKA**  
**Department of Health and Social Services**  
**INSTRUCTIONS TO BILLING AGENT FOR COMPLETING**  
**THE BILLING AGENT INFORMATION SUBMISSION AGREEMENT**

1. In the blank at the top of the form, fill in the Billing Agent business name:

I, \_\_\_\_\_, as Billing Agent, enter into this Billing Agent Information Submission Agreement with the State as authorization to submit, in either electronic or paper format, the Provider's clinical and financial information directly to the State on behalf of the Provider. All information submitted under the terms of this agreement is in support of services performed by the Provider.

2. ***Section I – Terms of Agreement***

Section I, items #1 through #13 – These items are statements that a Billing Agent agrees to when the Information Submission Agreement is signed. Please read all items carefully.

Section I, item #14 – Check the appropriate box. Please indicate if the information you submit will be HIPAA compliant or not.

Section I, item #15 – (a) – Check the appropriate box. Indicate whether *claims* information submitted to Alaska Medical Assistance will be in paper or electronic format.

(b) – Check the appropriate box. Indicate whether other information (see list in #17) submitted to Alaska Medical Assistance will be in paper or electronic format.

Section I, item #16 – Check the appropriate box.

a. If you will be sending your information directly from your office software to Alaska Medical Assistance, check the first box (*Billing Agent office system*).

b. If you are submitting information for a pharmacy provider and will use the Point of Sale (POS) system, check the 3<sup>rd</sup> box (*Point of Sale*).

Section I, item #17 – Check all boxes that apply or will apply within the next year. *If you do not plan to submit HIPAA-compliant transactions, check the last box, “N/A (Not Applicable).”*

Section I, item #18 – Complete this field only if you checked box 16a. If you will be using HIPAA-compliant software, fill in the requested information about your software vendor. If there are any technical problems with information submission, we may use the information you provide to contact the vendor.

Section I, item #19 – By signing the Billing Agent Information Submission Agreement, you agree to abide by items 19a – 19d.

Section I, item #20 – **This item must be completed for the Information Submission Agreement to be valid.**

The “Provider Business Name” field should contain the provider’s pay-to business legal name. This name must match the business name provided to the IRS.

The “State Provider Identification Number(s)” field should contain all Alaska Medicaid identification numbers for the provider named above.

Complete the name, mailing and physical address information about the Billing Agent (you).

Provide Billing Agent contact information for someone who can discuss your Information Submission Agreement or submitted information with Affiliated Computer Services, Inc. or the State of Alaska.

The “Billing Agent’s Authorized Representative Name and Title,” and “Signature of Billing Agent’s Authorized Representative” fields should contain an individual’s name and title. An authorized representative must be a general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the Billing Agent’s company, or must hold a position of similar status and authority within the Billing Agent’s organization.

**3. Sections III, IV** – Do not complete. These sections are reserved for the State of Alaska and Affiliated Computer Services.

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

---

**Print Authorized Representative Name**

---

**Title Authorized Representative**

---

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

---

**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**