# EDI CHANGE OF SUBMITTER FORM

Check all lines of business that apply:
Part A J5 [ ] Part B J5 [ ] Part B Legacy [ ] Part A Legacy [ ]

NPI Number_____ PTAN Number_____

Change (aka New) WPS Submitter Number: _____ Effective Date:_____

Note: All information in shaded area is required.

**Signature**
I am authorized to sign this document on behalf of the indicated party. I am aware that any changes to the submitter ID may affect the receipt of electronic remittance advice (ERA). Any changes regarding ERA will require a new ERA Authorization Form (http://www.wpsic.com/edi/pdf/edi_ern_medb.pdf).

Provider Name _____

Provider Address _____

City/State/Zip_____ _____ _____

By _____ _____
Signature Printed name

Title_____ Date_____

Provider Contact Name _____ Phone # _____

Provider Email _____ Fax # _____

**Please mail or fax this completed form to:**

**Medicare Part A & B J5 MAC**
(IA, KS, MO, NE)
WPS Medicare EDI
1717 West Broadway
Madison, WI. 53713
Fax: (608) 223-3824
Phone: (866) 503-9670

**Medicare Part A Legacy**
(Multiple States)
WPS Medicare EDI
PO Box 1602
Omaha, NE 68101
Fax: (402) 995-0606
Phone: (866) 734-6656

**Medicare Part B**
(IL, MI, MN, WI)
WPS Medicare EDI
912 N Pentecost Drive
Marion, IL 62959
Fax: (618) 998-5170
Phone: (877) 567-7261