Wisconsin Physicians Service (WPS) Authorization Form for Electronic Remittance Advice Processing (ERA)

This form is intended to establish Electronic Remittance Advice (ERA) enrollment. The implementation process cannot begin until this questionnaire is completed. **If the form is received as not legible or not completed correctly, it will be returned to the provider for correction.** If you are a direct submitter, you must be assigned a submitter ID in order to receive the ERA. If you have not registered for a submitter ID, please access the WPS Trading Partner System (WTPS) at the following website: https://corp-ws.wpsic.com/apps/wtps-web/unauth/wtps.do. If you are not a direct submitter, the clearinghouse/third-party company/billing service submitter number should be used. Please return this form to the EDI Department, for the applicable line of business, as listed at the bottom of this form.
******This request could take up to fourteen business days to complete. ******

Part A providers need to select if this request is for a new submitter or if they want to add providers to their current submitter.

New Submitter: [ ] Add Providers: [ ]

<u>Check all lines of business that apply:</u>

Part A J5 [ ] Part B J5 [ ] Part B Legacy [ ] Part A Legacy [ ]

<u>Please identify the company that will be retrieving the Electronic Remittance Advices ERA) in this section:</u>

Provider/Physician: [ ] Corporate Office: [ ] Third Party Company/Clearinghouse: [ ]

Provider Name: ____

Provider Street Address: ____
(If the provider will be retrieving the ERAs, then they need to include the address that the services are rendered)

Provider City/ State/Zip: ____

Contact Person: ____
(Printed Name)

Contact Phone #:______________________________ Contact Fax #:______________________________
(Please incl. ext #)

Contact Email Address: ____

WPS Submitter ID: ___________________
(Please use only the WPS issued submitter ID that will be retrieving the ERAs)

Provider Identification Numbers:

Multiple providers may be listed on this form if they are at the same location. To retrieve ERA for additional providers at different locations, please complete a separate authorization form for each additional provider number.

Provider Name	Provider Number	NPI Number

I, ______________________________ of ______________________________ would like to
(Provider Contact Signature) (Provider Name)

receive ERAs effective, ____________________. (**All providers MUST include an effective date for this request)**
(Date)

☐ By checking this box, you are authorizing a Third Party Company/Clearinghouse to Retrieve ERA files on your behalf.

Please supply the complete name and address of theThird Party Company/Clearinghouse.

Name: ______________________________ Address: ______________________________

City: ____________________ State: ________ Zip: __________ Fax #:____________________

Contact: ______________________________ Contact Phone #:____________________
(Printed Name) (Please include extension #)

Contact Email Address: ____

Translation Software: If you are a direct submitter, you will need translation and printing software in order to view and print the Electronic Remittance Advice. MREP software, for part B providers, and PCPrint software for part A providers, is available to download from our website at the following addresses:

MREP: *http://www.wpsmedicare.com/part_b/business/mrep.shtml*

PCPrint: *http://www.wpsmedicare.com/part_a/business/pc_print.shtml*

Please mail or fax this completed agreement to:

Medicare Part B Legacy: **IL, MI, WI, MN**	**Medicare Part A & B J5:** **IA, NE, KS, MO**	**Medicare Part A Legacy:** **(multiple states)**
WPS Electronic Data Services	WPS	WPS
912 N. Pentecost Rd.	Attention: EDI	Attention: EDI
PO Box 5511 Marion, IL 62959	1717 W. Broadway Madison, WI 53713	P.O. Box 1602 Omaha, NE 68101
Phone # (877) 567-7261	Phone # (866) 503-9670	Phone # (866) 734-6656
Fax : (618) 998-5170	Fax : (608) 223-3824	Fax: (402) 995-0606