



WPS COMMERCIAL PROVIDER AUTHORIZATION FOR WPS ELECTRONIC REMITTANCE ADVICE

Due to privacy regulations, this request must be submitted by the provider's office or authorized billing agent.

*Check all lines of business that apply:

WPS Commercial _____ MCDFC _____ CCCW _____ CLTS _____ HIRSP _____
Southwest Family Care Alliance _____

*NOTE - TRICARE providers should use the appropriate TRICARE ERA request form.

The only version of electronic remittance available is 4010A1.

ERA PROVIDER INFORMATION

*PROVIDER/FACILITY NAME: _____

*PROVIDER/FACILITY TAX ID: _____

List below NPI's and correlating physical location requesting an electronic remittance advice (**attach additional sheet if necessary.**)

<u>GROUP NPI</u>	<u>*PHYSICAL LOCATION</u>	<u>*PAYMENT LOCATION</u>
1. _____	_____	_____
	_____	_____
	_____	_____
2. _____	_____	_____
	_____	_____
	_____	_____
3. _____	_____	_____
	_____	_____
	_____	_____
4. _____	_____	_____
	_____	_____
	_____	_____

If you add an additional service location in the future and wish to receive ERA for this new location, go to our EDI web site at http://www.wpsic.com/edi/pdf/edi_ern_wps.pdf download another form.

*REQUIRED



ERA REQUESTER INFORMATION

*Requesters Contact Name: _____

*Requesters Phone #/Email Address: _____

***Print Provider Authorized Name:** _____

***Authorized Signature:** _____ ***Date:** _____

EDI CLAIM INFORMATION

Who submits your EDI claims? Submitter #: _____

ERA RECEIVER INFORMATION

Who will be receiving your ERAs?

*Electronic Claim Payment/Advice Receiver # _____

If you don't use a Clearinghouse and receive your ERA's directly, what is your Receiver ID: _____

If you wish to receive ERA's (ANSI 835 file) direct to your office. *if you haven't already*, please register for a trading partner/ERA receiver number at; <https://corp-ws.wpsic.com/apps/wtps-web/unauth/wtps.do>. Place 5 digit assigned trading partner number in the field: _____

If you don't know your Clearinghouse Receiver ID, contact your Clearinghouse.

*Billing Service/Clearinghouse Name: _____

Contact Name: _____

Contact Phone#: _____

Contact Email address: _____

Date to begin ERA: _____

Due to HIPAA requirements, only one submitter ID per provider number may be established for ERA. The submitter ID on this request will be the only recipient of ERA for the provider(s) listed.

An original or faxed copy will be accepted. Please mail or fax your completed agreement to:

Wisconsin Physicians Service
Electronic Data Service
P.O. Box 8128
Madison, WI 53708-8128
Fax (608-) 223-3824

***REQUIRED**