



REQUEST TO DEACTIVATE ELECTRONIC REMITTANCE

This will be effective upon receipt. The only version of electronic remittance available is 4010A1. Due to privacy regulations, this request must be signed by the provider's office.

*Check all that apply:

TRICARE West Region _____ TRICARE For Life _____ TRICARE Overseas _____

ERA PROVIDER INFORMATION

*Submitter ID: _____

*PROVIDER/FACILITY NAME: _____

*PROVIDER/FACILITY TAX ID: _____

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

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

REASON FOR DEACTIVATION:

***REQUIRED**

Deactivate ERA 10/2009



ERA DEACTIVATION PROVIDER INFORMATION

*Contact Name: _____

*Phone #/Email Address: _____

*Provider Authorized Name: _____

*Authorized Signature: _____ Date: _____

(Authorized signature of provider is one who is authorized to sign other legal documents on behalf of the provider. **(Signature from the billing service or clearinghouse are not accepted)**)

*Effective Date of Deactivation of ERAs: _____

Please mail or fax this completed agreement to:

Wisconsin Physicians Service
Electronic Data Services
P.O. Box 8128
Madison, WI 53708-8128

Fax (608)223-3824

***REQUIRED**