



### 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 \_\_\_\_\_ MCDA \_\_\_\_\_ CCCW \_\_\_\_\_ 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/ASSOCIATED BILLING 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](http://www.wpsic.com/edi/pdf/edi_ern_wps.pdf) download another form.

\*REQUIRED



## ERA REQUESTER INFORMATION

\*Requesters Contact Name: \_\_\_\_\_

\*Requesters Phone #/Email Address: \_\_\_\_\_

\*Provider Authorized Requestor Name: \_\_\_\_\_

\*Authorized Signature: \_\_\_\_\_ \*Date: \_\_\_\_\_

## ERA RECEIVER INFORMATION

Who submits your EDI claims?

\*Submitter #: \_\_\_\_\_

\*Billing Service/Clearinghouse Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Contact Phone#: \_\_\_\_\_

Contact Email address: \_\_\_\_\_

\*Electronic Claim Payment/Advice Receiver # (5 digit # assigned by WPS): \_\_\_\_\_

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

If you don't use a Clearinghouse and you don't know your submitter ID, Contact WPS.

\*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**