



REQUEST TO DEACTIVATE ELECTRONIC REMITTANCE

This will be effective upon receipt. The only version of electronic remittance available is 5010A1. Due to privacy regulations, this request must be signed by the provider's office.

ERA INFORMATION

Submitter ID: _____ Provider ID _____ NPI Number _____

Provider Name: _____

Provider Address: _____

City/State/Zip: _____

Contact Name: _____ Phone #: _____

E-mail address of person to be notified: _____

Reason for deactivation:

Provider Signature: _____ Date: _____

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

Please mail or fax this completed agreement to:

Please mail or fax this completed agreement 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