

Provider Name: _____

Provider Street Address: _____

Provider City, State and Zip: _____

Provider Contact: _____
(Printed Name)

Contact Phone # and Extension #: _____

Contact Fax #: _____

Please select the electronic service(s) you would like to add the above provider(s) to:

Electronic Media Claims: [] Electronic Remittance Advice: []

Claim Status Request and Response 276/277: []

Tax ID/Submitter # of the submitter listed on page one: _____

Which connection do you currently use to send/receive files to WPS Medicare?

Connect Mailbox: [] UHAR Mailbox/Logon ID: _____

VisionShare: []

Provider use only:

This section is to be completed by the facility if a clearinghouse/third party will be sending/receiving files for the facility. This section is not applicable to corporate offices.

I, _____ of _____ authorize
(Facility Contact Signature) (Facility Name)

_____ to send/receive files on our behalf, effective _____.
(3rd Party/Clearinghouse Name) (Date)

Once this request has been completed, we will contact you by phone or fax.

For questions, please call the EDI Department at 1-866-734-6656

Please Note: Sharing of IDs and passwords is strictly prohibited and is a violation of CMS and HIPAA privacy and security requirements. The IDs issued by WPS Medicare, for Connect Mailbox users, are for use solely by the company identified as the "Submitter" on page one of this form.