J15 HHH INTERNET EDI APPLICATION FORM

Part Action Requested: ☐ Apply for New Internet EDI ID ☐ Add Providers to Internet EDI ID ☐ Change/Update Internet EDI ID Information ☐ Delete Internet EDI ID

Internet EDI ID (if available): Date:

Submitter ID (if available):

Receiver ID (if available):

Internet EDI ID Holder's Name:

Owner(s) Name:

Type of Internet ID Holder: ☐ Software Vendor ☐ Billing Service ☐ Provider ☐ Clearinghouse

EDI Contact Person:

Phone: Fax:

Address:

City: State: ZIP:

Internet EDI ID Holder's Email Address:

Providers for Whom Internet EDI ID Holder Will Be Communicating Electronically:

Provider Name: Tax ID:

Provider Email Address:

Provider Number: NPI: Date:

☐ Submit Claim Status Request (ANSI 276)/Receive Claim Status Response (ANSI 277)
☐ Receive Electronic Remittances (ANSI 835)

I hereby authorize the above named Internet EDI ID Holder to transmit and receive the items selected above on my behalf. I understand that these items may contain payment information and PHI concerning my Medicare claims. I am authorized to endorse this access on behalf of my company, and I acknowledge that it is my responsibility to notify CGS EDI in writing if I wish to revoke this authorization. I acknowledge that if receiving Electronic Remittances CGS's public Internet is selected above, all other access to retrieving Electronic Remittances for the provider number noted above will be terminated.

Signature: Date:

Submit completed forms via fax to: 1.615.664.5947 - Home Health and Hospice | **Notes:** Please retain a copy for your records.

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