

**State of New Mexico Medicaid Program**

 **Electronic Data Interchange (EDI) Provider Authorization**

**Please return to:**

**E-Mail: HIPAA.DeskNM@hsd.nm.gov**

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| **Section A. Provider Information**  |
| *Business Person (Contact at provider’s office)*  |
| *Provider Name (Last, First, MI or Business Name)*  |
| **Provider NPI (if provider has NPI)**  | *Provider Tax ID / SSN (if provider does not have an NPI)*  |
| *Business Address*  |
| *City, State, Zip*  |
| *Telephone Number*  | *Fax Number*  |
| *Contact Name (Alternate contact)*  | *E-mail address*  |

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# \*Check box if this is a change in Billing Agent or Clearinghouse

**Section B. Authorization Signature (required)**

Provider, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby appoints *Provider name / Provider Representative name (please print)*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing Agent/Clearinghouse name (please print) Billing Agent/Clearinghouse Conduent Trading Partner/Submitter ID*

to act as the authorized agent for the purpose of submitting electronically to Conduent EDI Gateway, Inc.

 Provider also authorizes the Billing Agent/Clearinghouse access to the following X12N transaction responses (transaction must be selected):

\_\_ X12N 277 CA (Payer Specific Reject Report)

\_\_ X12N 999 (Acknowledgement of Sent Transactions)

\_\_ X12N 835 (Claim Payment Advice)

\_\_ X12N 271 (Eligibility Benefit Response)

\_\_ X12N 277 (Claim Status Response)

**This Authorization may be modified or revoked at any time in writing. It is considered in effect until modified or revoked. This**

**form must be completed by the billing provider, not a service only provider.**

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider/Provider Representative Name (please print) Provider/Provider Representative Signature/Date*

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