



Washington, DC Conduent EDI Provider Enrollment Form

Conduent
Technical Support/Enrollment
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Provider Conduent EDI Gateway Authorization Form for Billing Agents and Clearinghouses

Section A. Provider Information.
Please indicate your classification (required): [] Individual Provider [] Group Provider/Practice
Business Person
Provider Name (Last, First, MI and Suffix)
Provider Number (Required for Individuals) Group Provider Number (Required for Groups)
Business Address
City, State, and Zip
Telephone Number Fax Number
Contact Name E-mail Address

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 retrieving health care responses electronically from Conduent EDI Gateway, Inc. Provider also authorizes the Billing Agent/Cleringhouse's access to the following X12N transaction responses if selected below:

- [] 277-Claims Status Response [] 271-Eligibility Response
[] 277CA-Claim Acknowledgement [] 835-Healthcare Claims Payment Advice
[] 278-Prior Authorization Response [] 999-Functional Acknowledgement

Provider/Provider Representative name (Please print)

Provider/Provider Representative Signature

Date