

**L E T T E R   O F   A U T H O R I Z A T I O N**

**TO BE COMPLETED BY PROVIDER**

*Please complete the form below and return by mail to the address located at the bottom of this page. Faxed copies will be accepted.*

*This document is for the purpose of authorizing someone other than the Provider to submit or receive electronic data interchange (EDI) transactions on behalf of the Provider. All fields must be completed, and failure to include all necessary information may result in the rejection of this letter. An original signature is required from the Provider, CEO, CFO, COO or other duly authorized senior officer of Facility/Clinic.*

Provider or Facility Name	
Provider or Group Number	
Provider Submitter Number	

Billing Agent or Clearinghouse Name	
Billing Agent or Clearinghouse Submitter Number	
Effective Date	

*Select the date you want to begin submitting your claims through the billing agent or clearinghouse. Please be prepared to make your changes on the date you have indicated.*

By my signature below, I authorize the above named Billing Agent or Clearinghouse to submit or receive electronic data interchange (EDI) transactions of behalf of the above named provider.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Revised 8-15-05

RETURN TO:  
EDI-4BCS  
PO BOX 2181  
LITTLE ROCK, AR 72203-2181  
Fax (501) 378-2265