HUMAN SERVICES DEPARTMENT

State of New Mexico Medicaid Program
Electronic Data Interchange (EDI) Provider Authorization

Please return to:
Xerox State Healthcare, LLC
Mail to: P.O. Box 27460 Albuquerque, NM 87125
Fax: 1-866-226-1473
E-Mail: HIPAA.Desk.NM@Xerox.com

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)*
Busines Address	
City, State, Zip	
Telephone Number	*Fax Number*
Contact Name (Alternate contact)	*E-mail address*

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

Section B. Authoriztion Signature (required)

Provider, _____ hereby appoints
Provider name / Provider Representative name (please print)

Office Ally _____ 145627 _____
Billing Agent/Clearinghouse name (please print) *Billing Agent/Clearinghouse ACS Trading Partner/Submitter ID*

to act as the authorized agent for the purpose of submitting electronically to XEROX 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)

X 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*