



**AUTHORIZATION AGREEMENT FOR HIPAA TRANSACTIONS**

**CHC Payer ID: 48145**

**Provider Name:** \_\_\_\_\_ **Provider NPI Number:** \_\_\_\_\_

**Group Name (if requested for entire group):** \_\_\_\_\_ **Group NPI Number:** \_\_\_\_\_

I (we) hereby authorize **Community Health Choice, Inc.,** to initiate **one** of the following on my behalf:

Physician Management Software \_\_\_\_\_ Clearing House \_\_\_\_\_

Provider Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Submitter ID: \_\_\_\_\_ Receiver ID: CHC

**Transactions and Code Sets Implementation Standards:**

- 837 Institutional
- 837 Professional
- 276/277 Claims Status Inquiry and Response
- 270/271 Eligibility Inquiry and Response

I (we) elect to send the transaction code set by the following method: **(Select One)**

- CHC Secure Website
- CHC HTTP/FTP with PGP encryption
- CHC HTTPS/SFTP

This authorization is to remain in full force and effect until Community Health Choice, Inc. has received written notification from me (or either of us) of its termination in such time, and in such manner as to afford Community Health Choice, Inc. and Provider Entity a reasonable opportunity to act on it.

Tax ID Number \_\_\_\_\_ Signature \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact # \_\_\_\_\_ Date \_\_\_\_\_

Contact Email \_\_\_\_\_

**This Authorization may be faxed to 713-295-7020 – Attn: MedMc Team**