



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 Secure 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