

Service Center Authorization

Purpose: To authorize or terminate electronic transactions through a Service Center. A Service Center may be a clearinghouse or a provider business (direct submitter). Electronic transactions are processed only if authorized by the provider by use of this form. For Pharmacy transactions, contact the Technical Call Center at (800) 884-3238.

 Mail this form to First Health Services, EDI Coordinator, PO Box 30042, Reno, NV 89520-3042.

SERVICE CENTER SOURCE: Check one. Enter the business or clearinghouse name as appropriate.	
<input type="checkbox"/> I will submit claims through a clearinghouse. Clearinghouse Name: _____	FIRST HEALTH SERVICES USE ONLY SC Code: _____
<input type="checkbox"/> I will submit claims directly from my business to First Health Services (direct submitter). Business Name: _____	
AUTHORIZE A TRANSACTION: Check the box next to each transaction you wish to authorize.	
<i>I hereby authorize the Service Center named above to submit transactions on behalf of the provider until the provider notifies First Health Services otherwise by use of this form.</i>	
<input type="checkbox"/> Eligibility Request/Response (270/271)	<input type="checkbox"/> Professional claim (CMS-1500 claim: 837P)
<input type="checkbox"/> Prior Authorization Request/Response (278/278)	<input type="checkbox"/> Institutional claim (UB-92 claim: 837I)
<input type="checkbox"/> Claims Status Request/Response (276/277)	<input type="checkbox"/> Dental claim (Dental Claim: 837D)
<input type="checkbox"/> Electronic Remittance Advice (835)*	
<small>* Paper remittance advices will cease 30 days after electronic remittance advices begin. Although multiple Service Centers may submit claims for one provider, only one Service Center can receive the electronic remittance advice.</small>	
TERMINATE A TRANSACTION: Check the box next to each transaction you wish to terminate.	
<i>I no longer authorize the Service Center named above to submit transactions on behalf of the provider unless the provider notifies First Health Services otherwise by use of this form. (Enter the effective date below.)</i>	
<input type="checkbox"/> Eligibility Request/Response (270/271)	<input type="checkbox"/> Professional claim (CMS-1500 claim: 837P)
<input type="checkbox"/> Prior Authorization Request/Response (278/278)	<input type="checkbox"/> Institutional claim (UB-92 claim: 837I)
<input type="checkbox"/> Claims Status Request/Response (276/277)	<input type="checkbox"/> Dental claim (Dental Claim: 837D)
<input type="checkbox"/> Electronic Remittance Advice (835)	
Effective date for termination of this transaction(s): _____	

I understand that I am responsible for the information presented on claims that are submitted through the Service Center designated above and that all information presented on this authorization form is true, accurate, and complete. I further understand that payment and satisfaction of Nevada Medicaid and Nevada Check Up claims will be from federal and state funds and that false claims, statements, documents or concealment of material facts may be prosecuted under applicable federal and state laws.

Provider Name: _____ Phone: _____

Provider Medicaid Number (one per form): _____

Group Medicaid Number (one per form, if applicable): _____

Federal Tax ID Number (or SSN): _____

Will you be submitting claims that have more than one payer (COB/TPL claims)? Yes No

Provider Signature: _____ Date: _____