400 Vermillion Street • Hastings, MN 55033
Ph 800-482-3518 • Fax 651-389-9152
www.edsedi.com

WYOMING MEDICAID

DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION

PAYER ID NUMBER	**CKWY1**
ELECTRONIC REGISTRATIONS Agreements Required	**Provider ACS EDI Gateway Authorization Form for Billing Agents/Clearinghouses** • Sec A Provider Information – please complete all required information • Sec C Authorization Signature – Provider name, Provider signature and date **Electronic Dental Services Provider Enrollment Form** • Please complete all requested information.
ENROLLMENT CONFIRMATION	Please mail or fax completed forms to: Electronic Dental Services 400 Vermillion Street Hastings, MN 55033 Attn: Provider Enrollment Fax: 651-389-9152
CHANGING ELECTRONIC BILLING AGENTS	Enrollment will be coordinated between Electronic Dental Services and ACS EDI Gateway. Once approval is received Electronic Dental Services will contact the provider or their software vendor.
CONTACT PHONE NUMBERS	If the Provider currently submits claims through another Billing Agent other than Electronic Dental Services each Provider must re-enroll following the procedures listed above.
	Wyoming Medicaid 800 251-1268 ACS EDI Gateway, Inc 800-672-4959 Electronic Dental Services 800-482-3518

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PROVIDER ENROLLMENT FORM

Print/Type the following:
Insurance Carrier: **Wyoming Medicaid – payer ID CKWY1**

Provider/Organization Name: _____

Tax Identification or Social Security Number: _____
(Number that will be used to submit electronic claims)

Software Vendor: ___EDS_____

Group Number: _____
(if applicable)

Group NPI: _____
(if applicable)

Name	Rendering Number	NPI
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: ___Terri_____

Telephone Number: ___651-480-8090_____ Fax Number: _____

Date: _____

Wyoming ACS EDI Provider Enrollment Form

Please return to:
Attn: EDI Enrollment Unit
ACS EDI Gateway, Inc.
2324 Killearn Center Boulevard
Tallahassee, Florida 32309
Or fax to 850.385.1705

Provider ACS EDI Gateway Authorization Form for Billing Agents/Clearinghouses

Section A. Provider Information

Please indicate your classification **(required):** ☐ Individual Provider ☐ Group Provider/Practice

Business Name	
Provider Name (Last, First, MI and Suffix)	
Provider Number (Required for Individuals)	*Group Provider Number (Required for Groups)*
Business Address	
City, State, and Zip	
Telephone Number	*Fax Number*
Contact Name	*E-mail Address*

Section B. Reports and Responses Available

☑ X12N 997 Functional Acknowledgement	☐ X12N 271 Eligibility Response
☑ X12N 277 Claims Status Response	☐ X12N 824 Error Report
☐ X12N 278 Response	

Section C. Authorization Signature *(required)*

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

Claims Processing Service, Inc. , **12203**
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 health care transactions electronically to ACS EDI Gateway, Inc. Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected above:

_____
Provider/Provider Representative Name (Please print)

_____ _____
Provider/Provider Representative Signature *Date*

ACS EDI Gateway, Inc. 2324 Killearn Center Blvd., Tallahassee, FL 32309
1.800.672.4959 (phone) 1.850.385.1705 (fax)
www.acs-gcro.com