

SUBMITTER INFORMATION UPDATE FORM

All fields are required fields on this form in order that we can have correct and up-to-date information in our files.

Submitter ID (one alpha & four numeric): _____
Example: E9999

Submitter's Clinic or Association Name: _____

Submitter's Street Address: _____ City _____ State ____ Zip Code _____

Mailing Address (if different): _____ City _____ State ____ Zip Code _____

Office e-mail address _____ Telephone # _____ Fax # _____

The Contact Person field on this form refers to the individual(s) that will be allowed to discuss matters related to the daily transmission of electronic claims, receipt of reports, and password resets.

Contact Person #1 _____ Telephone # _____ E-mail Address _____

Contact Person #2 _____ Telephone # _____ E-mail Address _____

Contact Person #3 _____ Telephone # _____ E-mail Address _____

Please indicate software and version you will use to submit your ANSI 4010A1 files.
(Disregard if you are using a clearinghouse or billing agent.)

SOFTWARE

VERSION

Signature

Title

Date