

MEDICARE REMOTE SYSTEM ACCESS AGREEMENT
AUTHORIZATION FOR THIRD PARTY ACCESS

_____ (“Provider”) hereby notifies WPS that it has authorized a Third Party Service Organization, identified more fully below, to perform some or all of the Duties of Provider, as set forth in the Medicare Remote System Access Agreement (“Agreement”), between Provider and WPS.

The Third Party Service Organization has been advised of the terms and conditions of the Agreement and, by signing below, has agreed to be bound by the Agreement as if it was a signatory to the Agreement. The Provider, the Third Party Service Organization, either or both shall be responsible for the performance of the Duties and obligations contained in the Agreement.

By accepting this Authorization, WPS hereby agrees to coordinate its Duties with the Third Party Service Organization and to take reasonable steps to coordinate the applicable Fees, so as to minimize costs to the Provider and the Third Party Service Organization.

This authorization shall not be effective unless and until signed by an authorized representative of WPS.

 (“Provider” Name and Provider #)

 (“Third Party Service Organization”)

 Provider NPI #

 Printed Name and Title

 Printed Name and Title

 Signature

 Signature

 Printed Address

 Printed Address

 Telephone Number

 Telephone Number

 Fax Number

Date: _____

Date: _____

Third Party Use Only:

If you currently have access to the Remote System, please list the Logon IDs you would like the provider number(s) added to:

If you do not currently have access to the Remote System, please list the names of the employees that need IDs:

