

**MARYLAND MEDICAL CARE PROGRAMS
SUBMITTER IDENTIFICATION FORM**

For Version 005010 HIPAA Transaction Set

The provider, _____ hereby authorizes

PROVIDER NAME

_____, hereafter

SUBMITTER AGENT

referred to as Submitter Agent, to transmit HIPAA transactions to Maryland Medical Care Program, and further authorizes Maryland Medical Care Program to transmit to the Submitter Agent the return computer electronic files of all data processed. The Submitter Agent agrees to protect the confidentiality of this data as required by law.

Signature of Provider

Signature of Submitter Agent

Print Name of Signature

Print Name of Signature

Telephone Number

Date

Telephone Number

Date

Note: This form requires completion of all requested information and original signatures to be processed.

MAIL TO:

**SYSTEMS LIAISON SERVICES
201 W. PRESTON ST., RM SS-18
BALTIMORE, MD 21201
ATTN: HIPAA DESK**

For Internal Use Only:

Systems Liaison Services Signature: _____

Date Received: _____