



Electronic Transaction Agent Designation Letter

Independent Health Association, Inc.
Attn: e-Commerce Dept.
511 Farber Lakes
Buffalo, New York 14221

Date: _____

Dear Sir or Madam:

I, _____, authorize _____ to
Authorized Agent for Covered Entity Clearinghouse/Payment Processor
exchange electronic files and access electronic documents, as described

below, with Independent Health Association, Inc. for _____.
Covered Entity

I further certify that a valid Business Associates Agreement is in effect

between: (1) the _____ and _____
Clearinghouse/Payment Processor Covered Entity
and its subsidiaries and (2) _____ and _____.
Covered Entity Authorized Agent for Covered Entity

We are requesting access to the following types of files to exchange and/or review:

- ☐ 837 Electronic Claim Files and Response Files
- ☐ 835 Electronic Remittance Advices
- ☐ Electronic Documents on Reveal (Requires Reveal Intake Form & User Agreement)

Sincerely,

Signature of Authorized Agent for Covered Entity

Date

Printed Name of Authorized Agent for Covered Entity

Tax ID

Address

Submitter/Trading Partner ID

City, State, Zip Code

Telephone Number (including Area Code)

Please fax this letter to (716) 929-1062. No information will be released to the Clearinghouse/Payment Processor until a signed letter is returned to Independent Health.