Appointment of Authorized Provider Representative or Agent Form

MISSISSIPPI DIVISION OF MEDICAID

Provider:	Provider Number: NPI:

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicaid the provider or supplier):

I appoint this individual or agent,_____, to act as my representative to submit claims and other billing documents at my direction to the Mississippi Division of Medicaid. This individual may also use my electronic signature, typed signature, stamped signature on my behalf, at my direction, to make such submissions. When using my electronic, typed, or stamped signature, this individual must also accompany my electronic, typed, or stamped signature with their own printed name, either in electronic or handwritten form.

Signature of Provider		Date
Street Address		Phone Number
City	State	Zip Code
Email Address		

Section 2: Acceptance of Appointment

To be completed by the representative:

I,_____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS), licensure agency or Mississippi Department of Health (MSDH). I additionally certify that I have not been convicted of or pleaded guilty to or nolo contendere to a felony or certain misdemeanors including, but not limited to, fraud, forgery, counterfeiting, embezzlement, identity theft, tax evasion, money laundering, or any other crime related to dishonesty or concealment, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

I am a / an _____

(Professional title as it relates to the Provider)

Signature of Representative		Date
Street Address		Phone Number
City	State	Zip Code
Email Address		