Administrative Simplification Compliance Act (ASCA)
Waiver Request Form

All fields marked with * are required and must be completed or the request will be rejected.

*Provider Information *(Complete using your billing/group information only - member information is not needed)*

*Provider name:	*Street address:	
*City	*State	*ZIP
*Email address for enrollment response:	*Telephone number with extension:	
*Provider Transaction Access Number (PTAN):	*National Provider Identifier (NPI):	

*Waiver Request Reason *(choose one reason explaining why you need a waiver to submit claims on paper)*

- ☐ Small provider. Indicate the number of FTE employees:
  - *You must include the 941 tax statement for the previous quarter.
- ☐ Roster Biller of flu, pneumonia or COVID vaccines
- ☐ Dentist
- ☐ Claims under a Medicare demonstration project
- ☐ Claims rendered out of the US
- ☐ Tertiary claims (claims where more than one payer is primary to Medicare)
- ☐ Unusual Circumstances (choose one reason below explaining the unusual circumstance)
  - ☐ Service Interruption (interruption to phone lines, electricity, communications, or out of offfice)
    - Date interruption began: Reason for interruption:
  - ☐ Provider submits less than 10 claims a month
  - ☐ Other unusual circumstance - provide detailed explanation:

The Authorized Offical signing this form should be an AUTHORIZED OR DELEGATED OFFICIAL that was listed on the Medicare Enrollment Application (CMS-855). I hereby attest that my response and the information provided on this document are true, complete, and accurate, and I understand that this information may be used to verify my identity.

*Required Signatures

*Written Signature of Person Submitting Enrollment (add after you print the form)	*Date:
*Printed Name of Person Submitting Enrollment	*Printed Title of Person Submitting Enrollment:

Send via UPS mail to: First Coast Medicare EDI
P.O. Box 3703
Mechanicsburg, PA 17055-1861
or fax to: (904) 361-0470
or email to: MedicareEDI@fcso.com

Print Form Clear Form

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