# Electronic Delivery Form

Providers who wish to participate in the Electronic Delivery Enhancement may use this form to indicate their preferred delivery method and the related information. Documents to be delivered electronically are Alerts, the Provider Insider and Provider Notices. Please read over the below instructions prior to completing the form.

| Block | Guidelines |
|---|---|
| 1 | If completing this request to update a business/facility, such as a Durable Medical Equipment (DME) facility, please indicate the name of the business/facility. If completing this request to update a group/payee, such as a physician practice, indicate the group/payee/practice name. Please be aware that the delivery of electronic alerts/notices will be made only in the method selected to only the provider indicated. Only one Electronic alert/notice will be sent to a group/payee. |
| 2 | Indicate the eight to nine character provider number assigned under the provider name indicated in Block 1. |
| 3 | Options are offered to allow providers to receive Alerts, Provider Insiders and Provider Notices via e-mail or facsimile. Please indicate how your office would prefer to receive such documents. Selections are shown in blocks 3A and 3B. *Only one option may be chosen.* |
| 4 | Providers who indicate the media of E-mail will receive Alerts, Provider Insiders and Provider Notices in an Acrobat (PDF) format via e-mail. These documents will be forwarded to the e-mail address indicated in block 4. |
| 5 | Providers who indicate the media of Fax will receive Alerts, Provider Insiders, and Provider Notices via fax. These documents will be faxed to the fax number listed in block 5. |

1. Business/Group/Provider

   Name:

2. Alabama Medicaid Provider

   Number:

*Please indicate only one provider name and number in the spaces above. Please ensure the number indicated is assigned to the provider whose name is indicated.*

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| 3. Alerts/Insider/Notice: (Please check one option below:)<br><br>A.) E-mail ☐ (If checked, please complete Block 4)<br><br>B.) Fax ☐ (If checked, please complete Block 5) |
| 4. Email Address: |
| 5. Business Fax: |

*I certify that, to the best of my knowledge, the information supplied in this request is accurate, complete and is hereby released to Gainwell for the purpose of updating the Alabama Medicaid number (s) assigned to the named provider (s).*

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|---|---|
| ***Signature*** | ***Signature Date*** |
| ***Print Name of Person Signing Form*** | ***Indicate Title of Person Signing Form*** |

*(Signature must be hand written and must be the signature of personnel authorized to make changes for the named provider (s).* ***Black ink is required.***)

## Mailing Instructions

Print a copy of the completed form and mail or fax it to the Provider Enrollment team. Note: Please print a copy of the form for your records.

- **Mailing Address:** 301 Technacenter Drive, Montgomery, AL 36117 or P O Box 241685, Montgomery, AL 36124
- **Facsimile Number:** (334) 215-4298

If you have any questions concerning this form, please feel free to contact us at 1-888-223-3630 (in Alabama) or 334-215-0111 (outside of Alabama).