

## Customer Authorization

### **Agreement:**

I, \_\_\_\_\_, by my signature affixed hereto, empower, direct, and authorize Quantum Health Automation, Inc. to execute, print, copy, duplicate or otherwise affix my signature to the following medical forms:

1. HCFA-1500 Medical Forms
2. UB-92 Medical Forms
3. Dental Forms
4. Agreements for Submission and Reception of Electronic Healthcare Transactions such as claims and remittance advise.

I have provided QHA with all provider numbers for Group and Individual Identification Numbers, Tax Id Number, Social Security Number, to be used as needed in the forms stated above. I will further acknowledge that QHA will be relying on the accuracy of that information.

I DO NOT authorize QHA to use my provider numbers for identification in cases not required by the Payer.

The purpose of this document is to authorize QHA for service stated and no other reason. Any attempt to otherwise duplicate said signature will be of no force or effect.

The parties to this agreement agree that this agreement may be executed simultaneously or in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. The parties agree that this agreement may be transmitted between them by facsimile machine and electronic mail. The parties intend that faxed signatures constitute original signatures and are binding on the parties. The original document shall be promptly executed and/or delivered, if requested.

\_\_\_\_\_  
**Authorized Signature**

\_\_\_\_\_/\_\_\_\_/\_\_\_\_

Title

Date

Please STAMP your practice name & address.

• **Please mail this form to:**

Quantum Health Automation, Inc.  
201 N.W. 4th Street, Suite 103  
Evansville, IN 47708  
Attn: New Accounts Dept.

-or-

• **Fax this form to:**

1-812-468-8478  
Attn: New Accounts Dept.

**Thank you for your cooperation,  
Quantum Health Automation, Inc.**