PROVIDERGATEWAY-LTC™

SUBSCRIPTION SERVICE ORDER FORM

PAYER'S CONTACT INFORMATION	FACILITY COVERED BY THIS SUBSCRIPTION
Organization's Name (i.e., Location of Corporate Accounting):	**Facility Name:**
Billing Point of Contact:	**Point of Contact or Representative at Facility:**
Address:	**Facility Address:**
Phone - area code first:	**Facility Phone Number- area code first:**
Fax:	**Facility Fax:**
Email:	**Facility Email:**

SUBSCRIPTION INFORMATION

Effective Dates: **Term:** **X Annual** ☐	**Other:** **See Site Use and Confidentiality Policy** *(located at https://ltcmedicaid.providergateway.com)*

Subscribed Services: Online capabilities to manage the Admission-to-Discharge 9401 transaction cycle, including submission of transactions to County DJFS, secure forwarding of transaction documents to Department of Medicaid designated authorities including Admissions, Discharges, Change of Income/Patient Liability, One Time Payment, and Change of Admission 9401 transactions.

Service Fee:

USERS	RATE
Up to Three (3) Users	**Standard Fee ($1,350/Annual)**
N/A	**(Additional users at$95/mo)**

Total Due: $ 1,350

Payment Method see instructions immediately following):

- ☐ **Automatic Payment (ACH Debits)***
- ☐ **Check ****
- ☐ **Credit Card**
  - ☐ **MasterCard** ☐ **VISA** ☐ **Other**
  - **Card No.** _____
  - **Expiration Date** _____

* **ACH PAYMENTS:** Please complete and email with completed authorization form (next page) to **billing@providergateway.com**

** **CHECKS: Make check payable to Parthenon Globalsystems, LLC** and in memo field enter PROVIDERGATEWAY SUBSCRIPTION. You may also send an email to billing@Providergateway.com to ensure no lapses in the subscription prior to check being received.

Mail to: Parthenon Globalsystems, LLC
Attn: ProviderGateway Subscriptions
3615 Superior Avenue, Suite 3102G, Cleveland OH 44114.

CUSTOMER ACCEPTANCE/ AUTHORIZATION

Acknowledgment: I understand and accept the terms and conditions on this form and agree to be bound by the terms and conditions of the site use and confidentiality policies found on website at https://ltcmedicaid.providergateway.com.

Signature: _____ Name (Print) _____

Title: _____ Date: _____

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ACH AUTHORIZATION FORM

AUTHORIZATION

I hereby **authorize** Parthenon Globalsystems, LLC, its owners, agents, and financial institutions, to initiate electronic debit entries to my checking account(s) listed below. This authorization will remain in effect for all related amounts due under the Subscription Service Order Form for the online service.

This form grants the authorization to perform this electronic banking transaction to gain access to the ProviderGateway-LTC system. It is the customer's responsibility to review all invoices and/or Subscription Service Orders for amounts due and resolve any discrepancies that may exist prior to funds being withdrawn.

Company Name: _____

Company Address: _____

_____

Authorized by (Name): _____ Title: _____

Signature: _____ Date: _____

BANK INFORMATION:

Bank Name: _____ Phone: _____

Address: _____

Account Type: ☐ Checking ☐ Savings

Routing Number: _____

Account Number: _____

Amount To Be Debited: _____