assertus®
YOUR HEALTHCARE TECHNOLOGY PARTNER

PROVIDER ENROLLMENT
TRANSMISSION AUTHORIZATION

By completing and signing this authorization, the healthcare Provider is authorizing Assertus Holdings, LLC to interchange its electronic Healthcare transactions with the Trading Partner acting as a Delegate Transmission Site for the Healthcare Provider as reported hereunder.

Delegate Transmission Site	Site Account Number	NPI
Kalix, Inc	kalixCH	
Provider Name	**Phone**	**Fax**
	( ) Ext.	( )
Type ☐ Solo Practitioner ☐ Group Practice	**Email**	
Street Address	**Postal Address** ☐ Same as Street Address	
	PR -	PR -

Notes:

Authorization

Hereby, I certify that I'm the Provider referenced above or an authorized representative and that the reported NPI on this form belongs to the Provider referenced above, and I authorize ASSERTUS Holdings, LLC for the interchange of related health care transactions thru the Delegate Transmission Site reported on this form. I understand that this authorization will remain active until canceled in writing. I also understand that it is my responsibility to monitor that every claims file submitted to Assertus has a positive confirmation receipt received and that I need to report to Assertus any missing confirmation receipts.

Billing Provider Authorized Signature	Date:	ASSERTUS Authorized Signature	Date: