

	DHS EDI Support Services DMAP Operations 500 Summer St NE, E44 Salem, OR 97301-1079 503-947-5347 (include ENTIRE address above)	Health Insurance Portability and Accountability Act EDI Registration
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You are required to sign a Trading Partner Agreement before completing this registration form. Please be sure to type or print clearly, and fill in **all required fields designated with an asterisk (*)**. Incomplete forms will NOT be processed. Once completed, send this form with the Trading Partner Agreement and the Application for Authorization Form to the address listed above. Please maintain a copy for your records.

Trading Partner Information

ONE	THIS REGISTRATION IS: <input type="checkbox"/> A NEW REGISTRATION <input type="checkbox"/> A REVISED REGISTRATION DATE:		
	*Name of Provider, Prepaid Health Plan, Clinic or Allied Agency		
	*Physical Address:		
	Secondary Address:		
	*City, State & ZIP:		
	*Phone Number:		Fax Number:

TWO	OR-DHS Provider Number:		
	*Provider/Contract # for which the submitter has authorization (see Exhibit A):	#	
	*National Provider Identifier (NPI):		
	*Taxonomy Code(s):		

THREE	Authorized Signer Information (legally authorized signer):		
	*Authorized Signer:		*Title:
	*Phone Number:		*Fax Number:
	*E-mail Address:		
	Secondary Contact:		Title:
	Phone Number:		Fax Number:
	E-mail Address:		

FOUR	Claims Contact Information		
	*Primary Contact:		*Title:
	*Phone Number:		*Fax Number:
	*E-mail Address:		
	Secondary Contact:		Title:
	Phone Number:		Fax Number:
	E-mail Address:		

Exhibit B – EDI Registration Form

Complete this page with EDI Submitter information. **You must also include EDI Submitter information for yourself if your company intends to submit its own transactions.**

EDI Submitter Information				
FIVE	*Company Name:		OR-DHS Submitter ID:	
	*Address Line 1:			
	Address Line 2:			
	*City, State & ZIP:			
	*Submitter Type: <i>Check ALL that apply</i>	<input type="checkbox"/> Billing Provider <input type="checkbox"/> Self <input type="checkbox"/> Clearinghouse/Billing Service <input type="checkbox"/> Managed Care <input type="checkbox"/> TPA <input type="checkbox"/> Other: _____		
<i>Please Specify</i>				
EDI Submitter's Contact Information <input type="checkbox"/> Third Contact on reverse (if needed)				
SIX	*Business Contact:		*Title:	
	*Phone Number:		*Fax Number:	
	*E-mail Address:			
	*Technical Contact:		Title:	
	*Phone Number:		Fax Number:	
	*E-mail Address:			
Authorized Transactions for: <input type="checkbox"/> FFS Provider or <input type="checkbox"/> Prepaid Health Plan				
SEVEN	*Check all transactions for which authorization should be registered.			
	<input type="checkbox"/> 837 Professional Claim Submission <input type="checkbox"/> 837 Dental Claim Submission <input type="checkbox"/> 837 Institutional Claim Submission <input type="checkbox"/> 835 Health Care Claim Payment/Advice (RA) <input type="checkbox"/> 270 Health Care Eligibility Benefits Inquiry <input type="checkbox"/> 271 Health Care Eligibility Benefits Response <input type="checkbox"/> 278 Health Care Services Review Request (Prior Authorization [PA]) – <i>Not available at this time</i> <input type="checkbox"/> 278 Health Care Services Review Response (Prior Authorization [PA]) – <i>Not available at this time</i>	<input type="checkbox"/> 276 Health Care Claims Status Request <input type="checkbox"/> 277 Health Care Claims Status Response <input type="checkbox"/> Status File Health Care Claim Status (PHP only) <input type="checkbox"/> 820 Group Premium Payments <input type="checkbox"/> 834 Benefit Enrollment/Maintenance <input type="checkbox"/> NCPDP Submission (PHP only) <input type="checkbox"/> NCPDP Response Report (PHP only) <input type="checkbox"/> NCPDP Point of Sale Submission/Response –		
	NOTE: OR-DHS is currently only accepting ANSI 4010A1 Formats.			
	Signature			
EIGHT	*Provider, Prepaid Health Plan, Clinic or Allied Agency Name:		*Phone:	
	_____		_____	
	*Signature (original only):	*Date:		
_____		_____		
Please Print Name:				
