



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 &
 Accountability Act
 EDI Registration
 Change Form**

Only enter the new information that needs to be updated on your original Trading Partner Agreement and Exhibits. Once completed, send this form to the address listed above. **Change forms must include the signature of the Trading Partner or an authorized EDI Submitter.**

Trading Partner Information

ONE	1. EFFECTIVE DATE:	<input type="text"/>	Tax ID #:	<input type="text"/>
	2. Name of Provider, Prepaid Health Plan, Clinic or Allied Agency:	<input type="text"/>		
	3. Physical Address:	<input type="text"/>		
	4. Secondary Address:	<input type="text"/>		
	5. City, State & ZIP:	<input type="text"/>		
	6. Phone Number:	<input type="text"/>	7. Fax #:	<input type="text"/>

TWO	OR-DHS Provider Number			
	8. Provider/Contract # for which the submitter has authorization (see Exhibit A):	<input type="text"/>		
	Submitter Name <input type="text"/>	# <input type="text"/>		
	9. National Provider Identifier (NPI):	<input type="text"/>		
	10. Taxonomy Code(s):	<input type="text"/>		

THREE	Authorized Signer Information (legally authorized signer, Exhibit B)			
	11. Authorized Signer	<input type="text"/>	12. Title:	<input type="text"/>
	13. Phone #:	<input type="text"/>	14. Fax #:	<input type="text"/>
	15. E-mail Address:	<input type="text"/>		
	16. Secondary Authorized Signer:	<input type="text"/>	17. Title:	<input type="text"/>
	18. Phone Number:	<input type="text"/>	19. Fax #:	<input type="text"/>
	20. E-mail Address:	<input type="text"/>		

FOUR	Claims Contact Information			
	21. Primary Contact:	<input type="text"/>	22. Title:	<input type="text"/>
	23. Phone Number:	<input type="text"/>	24. Fax #:	<input type="text"/>
	25. E-mail Address:	<input type="text"/>		
	26. Secondary Contact:	<input type="text"/>	27. Title:	<input type="text"/>
	28. Phone Number:	<input type="text"/>	29. Fax #:	<input type="text"/>
	30. E-mail Address:	<input type="text"/>		

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FIVE	31. Company Name:	<input type="text"/>	32. OR-DHS Submitter ID:	<input type="text"/>
	33. Address Line 1:	<input type="text"/>		
	34. Address Line 2:	<input type="text"/>		
	35. City, State & ZIP:	<input type="text"/>		
	36. Submitter Type: <i>Check ALL that apply</i>	<input type="checkbox"/> Billing Provider <input type="checkbox"/> Prepaid Health Plan	<input type="checkbox"/> Self <input type="checkbox"/> TPA	<input type="checkbox"/> Clearinghouse/Billing Service <input type="checkbox"/> Other: <input type="text"/>

Please Specify

SIX	EDI Submitter's Contact Information <input type="checkbox"/> Third contact on reverse (if needed)			
	37. Business Contact:	<input type="text"/>	38. Title:	<input type="text"/>
	39. Phone Number:	<input type="text"/>	40. Fax #:	<input type="text"/>
	41. E-mail Address:	<input type="text"/>		
	42. Technical Contact:	<input type="text"/>	43. Title:	<input type="text"/>
	44. Phone Number:	<input type="text"/>	45. Fax #:	<input type="text"/>
	46. E-mail Address:	<input type="text"/>		

SEVEN	Authorized Transactions for: <input type="checkbox"/> FFS Provider or <input type="checkbox"/> Prepaid Health Plan	
	47. Check all transactions for which authorization should be registered. <i>Transactions marked with an asterisk (*) are not available at this time.</i>	
		Adding
		Deleting
	<input type="checkbox"/> 837P Professional Claim Submission	<input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/> 837D Dental Claim Submission	<input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/> 837I Institutional Claim Submission	<input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/> 835 Health Care Claim Payment/Advice (RA) (Only one created per TP)	<input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/> Status File Health Care Claim Status (PHP only)	<input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/> 820 Group Premium Payments	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> 834 Benefit Enrollment and Maintenance	<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> 270 Health Care Eligibility Benefits Inquiry	<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> 271 Health Care Eligibility Benefits Response	<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> 276 Health Care Claims Status Request	<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> 277 Health Care Claims Status Response	<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> 278 Health Care Services Review Request (Prior Authorization [PA])*	<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> 278 Health Care Services Review Response (Prior Authorization [PA])*	<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> NCPDP Submission (PHP only)	<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> NCPDP Response Report (PHP only)	<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> NCPDP Point of Sale Submission/Response	<input type="checkbox"/> <input type="checkbox"/>	
Added: <input type="text"/>	Deleted: <input type="text"/>	
NOTE: OR-DHS is currently only accepting ANSI 4010A1 Formats.		

EIGHT	Signature	
	48. Provider, Prepaid Health Plan, Clinic or Allied Agency Name:	49. Phone:
	<input type="text"/>	<input type="text"/>
	50. Authorized Signature (original only as identified on TPA):	
	<hr/> Signature	
<input type="text"/>	51. Date:	
<hr/> Print Name	<input type="text"/>	