

# CMS EDI Enrollment Registration Form

Check box to indicate the type of Electronic Data Interchange (EDI) registration

New Request	Update Trading Partner/Submitter Information
Add Provider <sup>1</sup> /Supplier to Trading Partner/Submitter ID	Delete
Reactivate Trading Partner/Submitter ID	Other

## 1) General Information

*Do not write in shaded areas of this form. Refer to instructions for Form completion. You must have a Medicare provider number (refer to Center for Medicare & Medicaid Services (CMS) Form 855 to apply for a Medicare provider number) prior to completing this Registration Form. This Form requires a signature.*

Legal Business Name of Medicare Provider Or Supplier Submitting this Form	Doing Business As (DBA)	Street Address	City, State, ZIP	

EDI Contact Name	Title	Telephone Number	Email Address	Fax Number

Alternate EDI Contact	Title	Telephone Number	Email Address	Fax Number

Billing Provider Number (PTAN)	National Provider Identifier (NPI) Number	Provider Tax ID Number	Trading Partner/ Submitter ID	Receiver ID

EDI Trading Partner Name	Street Address	City, State, ZIP	Trading Partner/ Submitter ID	Receiver ID

Trading Partner/Submitter Type	Clearinghouse	Direct Submitter	Billing Service
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EDI Contact Name	Title	Telephone Number	Email Address	Fax Number

Alternate EDI Contact	Title	Telephone Number	Email Address	Fax Number

## 2) Contractor Information

Contractor Name	
Contractor Number (Payer ID)	
Name of Software Vendor/Product	
Data Transfer Method	
Effective Date:	

837 Institutional Claims	837 Professional Claims	837 Dental Claims
835 Remittance Advice	276/277 Claim Status	NCPDP Claims
		Other (specify)

<sup>1</sup> All subsequent references to provider are meant to encompass both provider and supplier.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0983. The time required to complete this information collection is estimated to average (hours) (minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850

## CMS EDI Enrollment Registration Form

### 3) Signed Authorization

***This form – in conjunction with the CMS EDI Enrollment Attestation Form – must be completed and signed by any provider/supplier applying for initial use of EDI or to report subsequent changes in the information furnished in a previously filed CMS EDI Enrollment Registration Form. This form is to be completed regardless of whether the provider/supplier conducts EDI directly with CMS, and/or one of the CMS contractors or indirectly via a designated Trading Partner/Submitter. For additional information on completing this form, please visit the contractor's website.***

I certify I am legally empowered to sign this Form on behalf of the Legal Business Name identified in Sections 1 of this Form. I acknowledge it in signing this, I bind this company or unincorporated organization to notify the CMS contractor in advance and in writing if changes have occurred to information reported in this Form or if it is necessary to revoke any designations made in this Form. I certify the information I have supplied in this Form is accurate.

As a CMS provider or supplier, I understand in signing this Form, I am responsible for payment of any fees for EDI services charged by any designated EDI Submitter/Receiver with whom I have elected to conduct business. I also understand that any acknowledgement, error reports, or query responses related to submitted transactions will be returned to any designated EDI Submitter/Receiver with whom I have authorized on this form, and CMS contractors are not permitted to send duplicate copies of outbound transactions to my organization as well as to the designated EDI Submitter/Receiver.

Print Name		Title	
Signature		Date	

***Return the completed CMS EDI Enrollment Registration Form (either email, fax, or hardcopy) to: (CMS contractor enters the fax number and address information here)***

**\*INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED\***

## CMS EDI Enrollment Registration Form

The following is supplemental information to assist the provider/supplier in completing the form. All fields are required unless otherwise noted.

New Request - Check this option to request a new Trading Partner/Submitter ID if you will be connecting to (enter MAC name here) directly to submit files and retrieve reports.

Add Providers to Trading Partner/Submitter ID - Check this option to be linked to an existing clearinghouse or billing service Trading Partner/Submitter ID.

Reactivate Trading Partner/Submitter ID - Check this option to reactivate an existing Trading Partner/Submitter ID.

Update Trading Partner/Submitter Information - Check this option to update the Trading Partner/Submitter ID information.

Delete - Delete Trading Partner/Submitter ID or provider from existing Trading Partner/Submitter ID.

Other - MAC specific instruction

### 1) General Information Instructions

#### *To be completed by the Provider/Supplier*

Legal Business Name of Medicare Provider or Supplier Submitting this Form - The name you use when reporting to the IRS for tax purposes. Enter the provider/supplier billing name (can be the same as Legal Business Name).

Doing Business As (DBA) - Enter business name if applicable.

Street Address, City, State, ZIP - Provide the Street Address, City, State, ZIP Code for the Legal Business Name.

EDI Contact Name - Enter the EDI contact name, title, telephone number, email address and fax number (optional) that corresponds to the billing name. Note: Person at provider office to contact for all EDI-related issues or questions.

Alternate EDI Contact - Enter an alternate Contact name, title, telephone number, email address and fax number (optional) that corresponds to the billing name. Note: Person at provider office to contact for all EDI-related issues or questions.

Billing Provider Number (Provider Transaction Access Number - PTAN) - Enter the PTAN associated with the provider. List all that are applicable.

National Provider Identifier (NPI) - Enter the NPI associated with the Billing Provider Number (PTAN). List all that are applicable.

Provider Tax ID Number - Enter the Tax ID associated with the Billing Provider Number (PTAN).

Trading Partner/Submitter ID - New submitters may leave blank; if a group practice, report the group Submitter ID

Receiver ID (Optional) - Enter the Receiver ID for electronic remittances.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0983. The time required to complete this information collection is estimated to average (hours) (minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850

# CMS EDI Enrollment Registration Form

## ***To be completed by the Trading Partner/Submitter***

**EDI Trading Partner Name** - Enter the Trading Partner Name, Street Address, City, State, ZIP Code associated with the EDI Trading Partner Name.

**Trading Partner/Submitter ID** - Enter the Submitter ID.

**Receiver ID (Optional)** - Enter the Receiver ID for electronic remittances.

**Trading Partner/Submitter Type** - Select the type of submitter.

**EDI Contact Name** - Enter the EDI contact name, title, telephone number, email address and fax number (optional) associated with the EDI Trading Partner Name. Note: Person at trading partner site to contact for all EDI enrollment issues or questions.

**Alternate EDI Contact** - Enter an alternate Contact name, title, telephone number, email address and fax number (optional) associated with the EDI Trading Partner Name. Note: Person at trading partner site to contact for all EDI enrollment issues or questions.

## ***2) Contractor Information Instructions***

**Contractor Name** - Contractor enters its own name on form prior to making available to providers/suppliers.

**Contractor Number (Payer ID)** - Contractor enters its own number on form prior to making available to providers/suppliers.

**Name of Software Vendor/Product** - Enter the name of the software vendor or product in the space provided.

**Data Transfer Method** - Enter the Data Transfer Method (e.g., SFTP)

**Effective Date** - This is the date that you want to have your change take effect that is associated with your Reason for Request

Please check the appropriate box to select electronic transactions. Please select all options that apply.