

# Centers for Medicare and Medicaid Services EDI Registration Form

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

<b>Legal Business Name of CMS Provider</b>	<b>Street Address</b>	<b>City, State, Zip</b>	<b>Billing Name of Provider / Supplier</b>
<b>Contact Name</b>	<b>Phone Number</b>	<b>E-Mail Address</b>	<b>Fax Number</b>
<b>Name of Performing or Attending Physician</b>	<b>National Provider Identifier (NPI) Number</b>	<b>Billing Provider Number</b>	<b>Submitter Number</b>
<b>Name of Security Officer/Approver for Organization</b>	<b>E-Mail Address</b>	<b>Telephone Number</b>	<b>Assigned UserID (Optional)</b>

2) *Contractor Information*

Contractor Name			Contractor Number		Effective Date	
	<i>Reason for Request A/C/D</i>	<i>Version</i>	<i>Name of Designated EDI Submitter/Receiver URL:</i>	<i>Name of Software Vendor/ Product URL:</i>	<i>Data Transfer Method URL:</i>	<i>Telecomm. Method URL:</i>
837 Claim						
NCPDP Claim						
835 Remittance Advice						
270/271 Eligibility						
276/277 Claims Status						
Other(specify)						

3) *Signed Authorization*

*This form must be completed and signed by all providers/suppliers to apply for initial use of EDI or to report subsequent changes in the information furnished in a previously filed EDI 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 EDI Submitter/Receiver. For additional information on completing this form, please visit the contractor's website.*

I certify that I am legally empowered to sign this Form on behalf of the Legal Business Name identified in Sections 1 of this Form. I acknowledge that 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 that the information that I have supplied in this Form is accurate.

As a CMS provider or supplier, I understand that 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 that CMS contractors are not permitted to send duplicate copies of outbound transactions to my organization as well as to the designated EDI Submitter/Receiver.

<i>Signature</i>		<i>Printed Name</i>		<i>Date</i>	
<i>Title</i>					

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

**\* INCOMPLETE APPLICATIONS WILL BE RETURNED. \***

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

# Centers for Medicare and Medicaid Services EDI Registration Form

Instructions for Completion of the Centers for Medicare and Medicaid EDI Registration Form

Many parts of the EDI Registration Form are self-explanatory. Following is supplemental information to assist the provider/supplier in completing the form.

## (1) General Information

**Legal Business Name of Medicare/Section 1011 Provider or Supplier Submitting this Form** The name you use when reporting to the IRS for tax purposes.

**Street Address, City, State, Zip** Provide the street address, city, state, and zip code for the Legal Business Name.

**Billing Name of Provider/Supplier** Enter the provider/supplier billing name (can be the same as Legal Business Name). Enter the name of a **contact person, phone number, email and fax** that corresponds to the billing name.

**Name of Performing Physician or Attending Physician** For professional claims, enter the performing physician. For institutional claims, enter the attending physician.

**NPI** Enter when available.

**Submitter #** New submitters may leave blank; if a group practice, report the group submitter #.

**Billing Provider #** Enter your billing provider number. Group members must report Group number. If you have been issued more than one **Submitter Number** or **Billing Provider Number**, enter those numbers on a separate piece of paper using the same table format of Section 1.

**Name of Security Officer/Approver for Organization** Enter the name of the Organization's assigned Security Officer/Approver. The person who will assume responsibility for accepting the ability to grant access to CMS/Medicare Contractor software application systems to other Users in the organization. This person will only approve of users from the same Organization

**Email of Security Officer/Approver for Organization** The email address of the Organization's assigned Security Officer/Approver.

**Telephone Number of Security Officer/Approver for Organization** The telephone number of the Organization's assigned Security Officer/Approver.

**User ID of Security Officer/Approver for Organization** The User ID given to the Organization's assigned Security Officer/Approver by the Administrator of the application system.

## (2) Contractor Information

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

**Contractor Number** Contractor enters its own number on form prior to making available to providers/suppliers.

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

**Reason for Request** Enter either "A" (add), "C" (change), or "D" (delete).

**Version** Enter the version of the transaction to be exchanged (e.g. for HIPAA professional claim transaction version 004010X098A1).

**Name of Designated EDI Submitter/Receiver** Click the URL, choose from the available options and enter it on the form in the space provided.

**Name of Software Vendor Or Product** Click the URL, choose from the available options and enter it on the form in the space provided.

**Data Transfer Method** Click the URL, choose from the available options, and enter it on the form in the space provided.

**Telecommunications Method** Click the URL, choose from the available options, and enter it on the form in the space provided.

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