Medicare 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 Medicare 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.

Legal Business Name of Medicare Provider or Supplier Submitting this Form	Street Address	City, State, Zip	Billing Name of Provider / Supplier

Contact		Phone No.		E-mail		Fax	
Name of Performing or Attending Physician		NPI		Billing Provider #		Submitter #	

2) Contractor Information

Contractor Name			Contractor Number		Effective Date	
EDI transaction or Service	Reason for Request A/C/D	Version	Name of Designated EDI Submitter/Receiver URL:	Name of Software Vendor/ Product URL:	Data Transfer Method URL:	Telecomm. Method URL:
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 Medicare providers/suppliers to apply for initial use of EDI or to report subsequent changes in the information furnished in a previously filed Medicare EDI Registration Form. This form is to be completed regardless of whether the provider/supplier conducts EDI directly with the Medicare contractor or indirectly via a Designated EDI Submitter/Receiver. For additional information on completing this form, please visit your Medicare 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 Medicare 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 Medicare 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 Medicare contractors are not permitted to send duplicate copies of outbound transactions to my organization as well as to the Designated EDI Submitter/Receiver.

Signature		Printed Name		Date	
Title					

Return the completed Medicare EDI Registration Form (either fax or hardcopy) to:

(Medicare contractor enters the fax number and address information here)

* INCOMPLETE APPLICATIONS WILL BE RETURNED.*   *CMS-10164*

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 (20 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

Instructions for Completion of the Medicare EDI Registration Form

Many parts of the Medicare 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 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 claims filing with Medicare carriers, enter the performing physician. For claims filing with Medicare intermediaries, 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.*

(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 either "H1"(HIPAA 5010A1), "H2" (the named HIPAA version to replace H1), or "H3" (the named HIPAA version to replace H2).*

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.*