

PROVIDER SERVICE OFFICE ELECTRONIC DATA INTERCHANGE OPTION SELECTION FORM

Please check one of the following:

_____ Begin Registration _____ Terminate Registration _____ Change Options

Provider Name (or Business Name): _____

National Provider Identifier (NPI): _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone Number: _____

Software/Practice Management System: _____

EDI INPUT/OUTPUT OPTIONS

Identify the INPUT FROM and RETURN OUTPUT OPTIONS for your office in the fields below.
For assistance, contact EDI Support at (916) 853-7373.

INPUT FROM: _____ Service Office (SO)
 _____ Billing Office (BO)
 _____ CH Clearing House (CH) (Name: Office Ally)

You will submit Claims, TARs and Adjustments (ANSI X 12 837). When available, you will submit TARs (ANSI X 12 278).
 Will you also submit: RTDs electronically? YES NO
 NOAs electronically? YES NO
 Claim Status Inquiry (ANSI X 12 276)? YES NO

RETURN OUTPUT OPTIONS when available (standard options are shaded):

EDI Document	Requested? (Circle One)		Send To (Circle One)		
Electronic RTDs	YES <input type="radio"/>	NO <input checked="" type="radio"/>	SO	BO	CH
Electronic NOAs	YES <input type="radio"/>	NO <input checked="" type="radio"/>	SO	BO	CH
Electronic EOB Supplemental Claim Data (if YES, CIRCLE ONE: SUMMARY or DETAIL)	YES <input checked="" type="radio"/>	NO <input type="radio"/>	SO	BO	CH <input checked="" type="radio"/>
Electronic X-Ray/Attachment Labels (CIRCLE ONE: 1-UP or 3-UP)	YES <input checked="" type="radio"/>	NO <input type="radio"/>	SO	BO	CH <input checked="" type="radio"/>
Report of Documents Awaiting Return Information (CP-0-978-P)	YES <input checked="" type="radio"/>	NO <input type="radio"/>	SO	BO	CH <input checked="" type="radio"/>
Report of EDI Documents Received (CP-0-973-P)	YES <input checked="" type="radio"/>	NO <input type="radio"/>	SO	BO	CH <input checked="" type="radio"/>
Remittance Advice (ANSI X 12 835) *	YES <input type="radio"/>	NO <input checked="" type="radio"/>	SO	BO	CH
Claim Status Inquiry Response (ANSI X 12 277)	YES <input type="radio"/>	NO <input checked="" type="radio"/>	SO	BO	CH
Treatment Authorization Request & Response (ANSI X 12 278)	YES <input type="radio"/>	NO <input checked="" type="radio"/>	SO	BO	CH

Authorized Applicant's Original Signature

Date

<u>FOR DENTI-CAL USE ONLY</u>	
C/H ID:	
Remote ID:	
P/W:	
CV:	

Return completed form to:

Medi-Cal Dental Program
 Provider Enrollment
 P.O. Box 15609
 Sacramento, CA 95852-0609

OPTSELCT (Rev. 0808)