
Exhibit C: EDI Registration Change Form

Within 10 days of any material change, Trading Partners must notify DHS of the change. You can submit most changes on the EDI Registration Change Form (Exhibit C).


Material changes include, but are not limited to:

- Changes of address or e-mail address
- Contract number or Contract status
- Identification of authorized individuals or EDI Submitter
- Upgrades to newer transaction versions (when released)
- The addition or deletion of authorized transactions, or
- Any other change that may affect the accuracy of, or authority for, an EDI Transaction.

Some changes require a new EDI Packet or new enrollment with DMAP. DHS requires the signature of the Trading Partner or Authorized Signer to validate the change.

You can download additional copies of this form on the EDI Testing and Registration Web page at <www.oregon.gov/DHS/admin/hipaa/testing_reg.shtml>.

Exhibit C

| | | |
|--|---|---|
|  | DHS-DMAP Encounter and Electronic Data Unit 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 Encounter and Electronic Data Unit 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: | | Tax ID #: |
| | 2. Name of Provider, Prepaid Health Plan, Clinic or Allied Agency | | |
| | 3. Physical Address: | | |
| | 4. Secondary Address: | | |
| | 5. City, State & ZIP: | | |
| | 6. Phone Number: | | 7. Fax #: |
| OR-DHS Provider Number | | | |
| TWO | 8. Provider/Contract # for which the submitter has authorization (see Exhibit A): | | # |
| | Submitter Name _____ | | |
| | 9. National Provider Identifier (NPI): | | |
| 10. Taxonomy Code(s): | | | |
| Authorized Signer Information (legally authorized signer, Exhibit B) | | | |
| THREE | 11. Authorized Signer | | 12. Title: |
| | 13. Phone #: | | 14. Fax #: |
| | 15. E-mail Address: | | |
| | 16. Secondary Authorized Signer: | | 17. Title: |
| | 18. Phone Number: | | 19. Fax #: |
| | 20. E-mail Address: | | |
| Claims Contact Information | | | |
| FOUR | 21. Primary Contact: | | 22. Title: |
| | 23. Phone Number: | | 24. Fax #: |
| | 25. E-mail Address: | | |
| | 26. Secondary Contact: | | 27. Title: |
| | 28. Phone Number: | | 29. Fax #: |
| | 30. E-mail Address: | | |

Continued on next page

EDI Submitter Information (Exhibit C: Page Two)

FIVE

| | | | |
|---|---|---|--|
| 31. Company Name: | | 32. OR-DHS Submitter ID: | tp000329 |
| 33. Address Line 1: | | | |
| 34. Address Line 2: | | | |
| 35. City, State & ZIP: | | | |
| 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: _____ <i>Please Specify</i> |

SIX

| EDI Submitter's Contact Information | | <input type="checkbox"/> Third contact on reverse (if needed) | |
|-------------------------------------|------------------------|---|---------------|
| 37. Business Contact: | Eve Du Bry | 38. Title: | |
| 39. Phone Number: | 949-464-9129 | 40. Fax #: | 949-376-6951 |
| 41. E-mail Address: | support@officeally.com | | |
| 42. Technical Contact: | Virginia Mungia | 43. Title: | Payer Support |
| 44. Phone Number: | 949-464-9129 | 45. Fax #: | 949-376-6951 |
| 46. E-mail Address: | | | |

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 currently unavailable.</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"/> 28 Line Roll/Split Report (837I submitters only) (inpatient claims only) | <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 (PHP only) | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input type="checkbox"/> 834 Benefit Enrollment and Maintenance (PHP only) | <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 (FCHP only) | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input type="checkbox"/> MMIS Web Portal for Claims/PA* | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input type="checkbox"/> Non-HIPAA Remittance Advice* | <input type="checkbox"/> | <input type="checkbox"/> | |
| Added: _____ | Deleted: _____ | | |

NOTE: OR-DHS is currently only accepting ANSI 4010A1 Formats.

Signature

EIGHT

| | |
|---|-------------------------|
| 48. Provider, Prepaid Health Plan, Clinic or Allied Agency Name: | 49. Phone: _____ |
| 50. Authorized Signature (original only as identified on TPA): | |
| | |
| Signature | |
| | 51. Date: _____ |
| Print Name | |