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| --- | --- |
| **Trading Partner/Organization Information:** | |
| Name: | Contact(s): |
| Tel: | Title: |
| Email: | Street Address: |
| Fax: | City/State/Zip: |

|  |  |
| --- | --- |
| **Select desired option:** | |
| Become a trading partner | Add provider or payee number(s) |
| Add transaction(s) | Change submission/retrieval method |

|  |  |  |
| --- | --- | --- |
| **Please indicate submission/delivery method.** *Check all that apply*. | | |
|  | SOAP+WSDL | HTTP+MIME |
| 276/277 Claim Status Inquiry & Response |  |  |
|  |  |  |

\*\* 270/271 Eligibility & Benefit Inquiry & Response is provided by Transunion on behalf of PHC, please contact Transunion directly.

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| --- |
| **EDI Sender ID Details:** |
| Trading partner name *(if applicable):* |
| ISA06 submitter ID: |
| GS02 sender ID: |
| Sending System IP Address *(or range):* |

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| --- | --- | --- | --- |
| **Primary Technical (IT) & Business Contacts** | | | |
| Technical Contact | Name: | Tel: | Email: |
| Business Contact | Name: | Tel: | Email: |

**Trading Partners Requirements and Legal Representations**

Each EDI transaction submitter will comply with the HIPAA Transaction Rule found at 45 CFR Parts 160 and 162, as amended.

Each EDI transaction submitted will comply with the format, data, connectivity, transmission and other requirements set forth in the applicable Companion Guide for each EDI transaction.

When determined necessary, before initiating any EDI transaction, Trading Partner will cooperate with PHC in such testing of the transmission and processing systems as deemed appropriate to ensure the confidentiality, integrity and availability of each data transmission.

EDI transactions will be retained for 7 years.

Trading Partner acknowledges that PHC had the right to audit and confirm information submitted by Trading Partner.

276/277 Transactions for direct-connect providers: PHC requires a list of all individual provider name(s), provider NPI(s) and tax ID (s) for which you will be submitting claim status inquiries.

Please note that the provider’s name, NPI and TIN must match current PHC provider information on record.

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| --- | --- | --- | --- |
| **Provider Name** | **Provider’s Billing NPI** | **Payee/Group NPI** | **Provider’s Tax ID#** |
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|  |  |  |  |

Please use additional sheet(s) as necessary.

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| --- | --- |
| **Signature: By signing below, I acknowledge that I am authorized to sign this document on behalf of the organization, and have read and agree to the provisions as set forth above.** | |
| Signature: | Date: |
| Print name: | Title: |

**Please e-mail completed form** to [EDI-Enrollment-Testing@partnershiphp.org](mailto:EDI-Enrollment-Testing@partnershiphp.org)