OHIO DEPARTMENT OF MEDICAID

DESIGNATION OF AN 835 TRADING PARTNER

By completing and signing this form the provider authorizes the department to transmit remittance advice data in an X12-5010 format through the EDI Trading Partner listed in Section II of this form. **All fields with an (*) are required.** Forms missing required information will not be processed. Please include information in other fields if it is available. ***Current date will be used if the Effective Date is not included***.

SECTION I: PROVIDER INFORMATION

Provider Name:*	Doing Business as Name (DBA):	
Street:*		
City:*	State/Province:*	ZIP Code/Postal Code:*

SECTION II: PROVIDER IDENTIFIERS INFORMATION

Provider Identifiers	Provider Federal Tax Identification Number (TIN)	National Provider Identifier (NPI):
	or Employer Identification Number (EIN):*	Medicaid Provider ID:*
Other Identifiers	Assigning Authority: **Ohio Department of Medicaid**	Trading Partner ID:*

SECTION III: PROVIDER CONTACT INFORMATION

Provider Contact Name:*		Title:	
Telephone Number:*	Extension	Email Address:*	Fax Number:

SECTION IV: ELECTRONIC REMITTANCE ADVICE INFORMATION

PREFERENCE FOR AGGREGATION OF REMITTANCE DATA

Provider Preference for grouping (bulking) claim payment remittance advice.

Provider Tax Identification Number (TIN): *Required if NPI is not applicable**	National Provider Identifier (NPI): *Required if TIN is not applicable**

SECTION V: ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

Clearinghouse Name:*	Clearinghouse Contact Name:*
Telephone Number:	Email Address:

SECTION VI: SUBMISSION INFORMATION

Reason for Submission:* ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment	Requested ERA Effective Date:

AUTHORIZED SIGNATURE

The signature of an individual authorized by the provider or its agent to initiate, modify, or terminate an enrollment.

Written Signature of Person Submitting Enrollment:*
Printed Name of Person Submitting Enrollment:*
Printed Title of Person Submitting Enrollment:

Send the completed form to

Ohio Department of Medicaid
MCD-EDI Support
P.O. Box 182709
Columbus, Ohio 43218-2709

Or eMail: omesedisupport@medicaid.ohio.gov