



**ELECTRONIC DATA INTERCHANGE (EDI)  
TRADING PARTNER PROFILE - PROVIDER**

State Form 51401 (R5 / 12-23) / Part of State Publication 286  
INDIANA DEPARTMENT OF HEALTH

Remittance Address:  
Indiana Department of Health  
Attn: OTC/EDI Department  
2 N Meridian St, 3K  
Indianapolis, IN 46204  
Telephone: 317-233-9803  
Fax: 317-233-8199

Reason for submission <input type="checkbox"/> New enrollment <input type="checkbox"/> Change enrollment <input type="checkbox"/> Cancel enrollment			Nine (9) digit taxpayer identification number (TIN) of the legal name		
Enter ten (10) digit National Provider Identification Numbers (NPI) of the legal name.					
Payee NPI					
Service NPI		Service NPI		Service NPI	
Service NPI		Service NPI		Service NPI	

PROVIDER OF SERVICE				
Name or provider				
Address (number and street, suite)		City	State	ZIP + 4
Name of contact				
Telephone number (    )	Fax number (    )	E-mail address		

SOFTWARE VENDOR INFORMATION				
<i>Providers, please complete this section if you are currently working with any Software Vendor. Please list all Software Vendor(s) used for submission of Medical, Dental, Institutional, Vision, and Pharmacy electronic claims. Attach additional Software Vendor(s) as needed.</i>				
Software vendor <input type="checkbox"/> X12 <input type="checkbox"/> NCPDP		Name		
Address (number and street, suite)		City	State	ZIP + 4
Name of contact				
Telephone number (    )	Fax number (    )	E-mail address		

CLEARINGHOUSE INFORMATION				
<i>(Providers, please complete this section if you are currently working with any clearinghouse / switch to submit transactions to the Indiana Department of Health.) Please list all Clearinghouse(s) used for the submission of Medical, Dental, Vision, and Pharmacy electronic claims.</i>				
Clearinghouse 1 <input type="checkbox"/> X12 <input type="checkbox"/> NCPDP		Name of clearinghouse1		
Address (number and street, suite)		City	State	ZIP + 4
Name of contact				
Telephone number (    )	Fax number (    )	E-mail address		
Clearinghouse 2 <input type="checkbox"/> X12 <input type="checkbox"/> NCPDP		Name of clearinghouse1		
Address (number and street, suite)		City	State	ZIP + 4
Name of contact				
Telephone number (    )	Fax number (    )	E-mail address		

**EDI TRANSACTIONS**

Indicate your request(s) for the EDI transactions below.

Remittance Advices are provided twice weekly and include claims submitted electronically and on paper.

Inbound (sent from you to IDOH):

- |   |  |
|---|--|
| <input type="checkbox"/> Health Care Claim (837)    | <input type="checkbox"/> Prior Authorization (NCPDP P1-P4)   |
| <input type="checkbox"/> Prior Authorization (278)  | <input type="checkbox"/> Billing / Reversal (NCPDP B1, B2)   |
| <input type="checkbox"/> Eligibility Request (270)  | <input type="checkbox"/> Re-bill (NCPDP B3)                  |
| <input type="checkbox"/> Claim Status Request (276) | <input type="checkbox"/> Eligibility Verification (NCPDP E1) |

Outbound (sent from IDOH to you):

- |   |   |
|---|---|
| <input type="checkbox"/> Payment Advice (835)       | <input type="checkbox"/> Claim Status Request (277) |
| <input type="checkbox"/> Prior Authorization (278)  | <input type="checkbox"/> Response (NCPDP B1, B2)    |
| <input type="checkbox"/> Eligibility Response (271) |   |

**DATA TRANSMISSION / RETRIEVAL**

Please complete if you will be submitting transactions directly from your office to Indiana Department of Health.

Method of data transmission / retrieval

- |                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/> Secure FTP | <input type="checkbox"/> Side by side VPN connection |
|-------------------------------------|--|

**AUTHORIZATION**

I am authorizing the outbound transactions indicated to be retrieved by:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Provider of Service | <input type="checkbox"/> Software Vendor / Third party vendor | <input type="checkbox"/> Clearinghouse/ Switch |
|--|---|--|

This Agreement may be executed simultaneously or in two or more counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument. The parties agree that this Agreement may be transmitted between them electronically or digitally. The parties intend that electronically or digitally transmitted signatures constitute original signatures and are binding on the parties. The original document shall be promptly delivered, if requested.

Authorized signature

Date (month, day, year)

Title of authorized signatory