Reset Form

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

State Form 51401 (R4 / 6-14) / Part of State Publication 286
INDIANA STATE DEPARTMENT OF HEALTH

Remittance Address:
Indiana State Department of Health
Office of HIPAA Compliance
EDI Division 3K
2 North Meridian Street
Indianapolis, IN 46204-3010
(317) 233-9803

| Reason for submission ☐ New enrollment ☐ Change enrollment ☐ 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 | 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**

*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.*

| Software vendor ☐ X12 ☐ NCPDP | Name | | |
|---|---|---|---|
| Address *(number and street, suite)* | City | State | ZIP + 4 |
| Name of contact | | | |
| Telephone number ( ) | Fax number ( ) | E-mail address | |

**CLEARINGHOUSE INFORMATION**

*(Providers, please complete this section if you are currently working with any clearinghouse / switch to submit transactions to the Indiana State Department of Health.) Please list all Clearinghouse(s) used for the submission of Medical, Dental, Vision, and Pharmacy electronic claims.*

| Clearinghouse 1 ☐ X12 ☐ 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 ☐ X12 ☐ 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.*<br>*Remittance Advices are provided twice weekly and include claims submitted electronically and on paper.* | |
| Inbound (*sent from you to ISDH*):<br>☐ Health Care Claim (*837*)<br>☐ Prior Authorization (*278*)<br>☐ Eligibility Request (*270*)<br>☐ Claim Status Request (*276*)<br>☐ Prior Authorization (*NCPDP P1-P4*)<br>☐ Billing / Reversal (*NCPDP B1, B2*)<br>☐ Re-bill (*NCPDP B3*)<br>☐ Eligibility Verification (*NCPDP E1*) | Outbound (*sent from ISDH to you*):<br>☐ Payment Advice (*835*)<br>☐ Prior Authorization (*278*)<br>☐ Eligibility Response (*271*)<br>☐ Claim Status Request (*277*)<br>☐ Response (*NCPDP B1, B2*) |

| DATA TRANSMISSION / RETRIEVAL |
|---|
| *Please complete if you will be submitting transactions directly from your office to Indiana State Department of Health.* |
| Method of data transmission / retrieval<br>☐ Secure FTP ☐ Side by side VPN connection |

| AUTHORIZATION | |
|---|---|
| **I am authorizing the outbound transactions indicated to be retrieved by:**<br>☐ Provider of Service ☐ Software Vendor / Third party vendor ☐ 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 | |