# EDI APPLICATION

**Date:**

**Line of Business/Payor ID:** KY Part A 15101 | KY Part B 15102 | OH Part A 15201 | X OH Part B 15202 | HHH 15004

**Action Requested:** Add Provider(s) | Change/Update Submitter Information | Delete | Apply for New Submitter ID

**Input Submitter ID #** (if applicable): 837 (for submitting claims): **B01787** 835 (to receive ERA):

**Note:** If submitter ID number for 835 field is left blank it will automatically default to the 837 submitter ID number requested unless you are currently setup for ERA/ERN. If requesting myCGS for ERA's, please enter myCGS in the 835 field.

**Name of Submitter ID:** **MD CLAIMS INC**

**Type of Submitter:** Software Vendor | Billing Service | Provider | X Clearinghouse

**EDI Contact Person:** **MIKE DYAS** **Phone:** **614 488 9525**

**2622 COVENTRY RD COLUMBUS OHIO 43221**

**Address**
**City, State, Zip:**

**Submitter E-mail Address**
(**Note:** E-mail will be the primary method of communication.)**:** **MIKE@MDCLAIMS.CC**

**Name of Software Vendor:** **NA**

**Name of Network Service Vendor (NSV):** **MEDTRAN DIRECT**

**PROVIDERS FOR WHOM SUBMITTER WILL BE TRANSMITTING:**

**Group Practice/Provider Name:**

**Provider Contact Name:** **Provider Telephone #:**

**Provider Address**
**City, State, Zip:**

**Group Provider Number:** **Group NPI:** **TIN/EIN #:**

**FAX completed form (for faster service) to:**

- 1.615.664.5945 - Ohio Part A
- 1.615.664.5927 - Ohio Part B
- 1.615.664.5947 - Home Health & Hospice
- 1.615.664.5943 - Kentucky Part A
- 1.615.664.5917 - Kentucky Part B

**Or mail completed form to:** J15 - Part B Correspondence
CGS
PO Box 20018
Nashville, TN 37202

I hereby authorize the above submitter to receive the items notated above on my behalf. I understand that this document binds me to electronic remittance also unless a waiver has been granted through EDI from CMS for SPR in accordance with publication reference IOM 100-4 chapter 22 section 40.1 In addition, I understand that these items contain payment information concerning my processed Medicare claims. I am authorized to endorse this access on behalf of my company, and I acknowledge that it is my responsibility to notify CGS EDI in writing if I wish to revoke this authorization.

**Authorized Signature** (Must be signed by Provider)

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