Ohio Department of Medicaid

DESIGNATION OF AN 835 or 834-820 TRADING PARTNER

By completing and signing this form the provider authorizes the department to transmit member enrollment and 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) or Employer Identification Number (EIN):*	National Provider Identifier (NPI):
Other Identifiers	Assigning Authority: **Ohio Department of Medicaid**	Medicaid Provider ID:*
		Trading Partner ID:* 0003829

SECTION III: PROVIDER CONTACT INFORMATION

Provider Contact Name:*		Title:
Telephone Number:* ( ) - ext.	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:* MD Cliams Inc	Clearinghouse Contact Name:* Michael Dyas
Telephone Number: 614-488-9525	Email Address: mike@mdclaims.cc

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:* Michael Dyas	
Printed Name of Person Submitting Enrollment:* Michael Dyas	
Printed Title of Person Submitting Enrollment: Owner MD Claims Inc	

Send the completed form to:
Ohio Department of Medicaid
P.O. Box 182709
Attn: ITS/EDI
Columbus, Ohio 43218-2709
or eMail: DAS-EDI-Support@das.ohio.gov, or Fax: (614) 644-8989