Oregon Health Authority

HEALTH SYSTEMS DIVISION
EDI Support Services

*National provider identifier (NPI):	
* Medicaid ID:	
*Taxonomy codes:	

Trading Partner Agreement (TPA) for Electronic Health Care Transactions

Pages 2–3: To be completed by the Oregon Medicaid Provider (trading partner).
Page 4: To be completed by the submitter or Clearinghouse.

If you have questions about what NPI, Medicaid ID, taxonomy codes or physical address should be listed, contact Provider Services at 1-800-336-6016, or email DMAP.ProviderServices@odhsoha.Oregon.gov.

Trading partners must complete and submit this form to:

- Sign up to exchange transactions with the Oregon Health Authority (OHA).
- Authorize who will exchange these transactions for you.
- Make any changes to trading partner or submitter information on file with OHA.

How to complete this form:

- Please type or print clearly. **Fill in all required fields designated with an asterisk (*)**.
- Incomplete or Illegible forms will be denied.
- You must be a registered Oregon Medicaid provider to bill electronically.
- You must use the National Provider Identifier (NPI) number, Medicaid ID number, Taxonomy codes, provider name and physical address on the TPA as **currently** registered in our system, otherwise the TPA will be denied.
- **You must complete one TPA per NPI and Medicaid ID as currently registered with Medicaid. If the TPA is submitted with multiple Medicaid ID's, the TPA will be denied.**
- **If the NPI number is currently registered to multiple Medicaid ID numbers, one TPA must be completed with one NPI and One Medicaid ID. TPA with multiple Medicaid ID numbers will be denied.**
- If you need to authorize more than one clearinghouse or submitter, complete a TPA for each one.
- If you need to authorize more than one clearinghouse or submitter, complete a TPA for each one.
- Please keep a copy for your records. We cannot provide a copy, once submitted.

Email the completed form as a PDF document and any questions to:

OHA.TPAgreements@odhsoha.oregon.gov
Fax forms to (503) 945-6898.
If you cannot submit by email or fax, you can mail forms to EDI Support Services, 500 Summer St NE E44, Salem, OR 97301.

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Form Section

Medicaid provider information:	
***Section 1: Medicaid provider information –** This page is to be completed and signed by the provider (referred to as trading partner) requesting this TPA.	
* **Business name:** (as enrolled with OHA)	
*Physical address: (as enrolled with OHA)	
*City, State and Zip:	
*Phone number with extension:	
***Section 2: Trading partner authorized signer information –** The primary signer signs Section 5 of this page. The authorized signer must be with the provider and **cannot be a billing service**.	
* **Primary authorized signer's name:**	
*Title:	
*Email address (individual, not group email)	
*Phone number with extension:	

* **Secondary authorized signer's name:**	
*Title:	
*Email address (individual, not group email)	
*Phone number with extension:	
***Section 3: Trading partner claims contact information –** List individuals and **not** groups.	
***Primary claims contact name:**	
*Phone number with extension:	
*Email address (individual, not group email)	

* **Secondary claims contact name:**	
*Phone number with extension:	
*Email address (individual, not group email)	
***Section 4: Electronic data interchange (EDI) Submitter Information –** • If your company intends to exchange transactions directly with OHA, enter the name (as listed in Section 1) as this will become the submitter name; or • If you intend to use a submitter or clearinghouse, complete this part with their information.	
***Submitter or clearinghouse name:**	
*Address:	
*City, State and Zip:	
*Submitter EDI Mailbox number:	MB000 _ _ _

Form Section

***Section 5: Authorized transactions –** Check all transactions that OHA should authorize for your EDI submitter.			
HIPAA 5010A1 transactions:			
☐	005010X222A1	837P	Professional claim submission
☐	005010X223A2	837I	Institutional claim submission
☐	005010X224A2	837D	Dental claim submission
☐	005010X221A1	835	Electronic remittance advice
☐	005010X279A1	270 and 271	Eligibility benefits inquiry and response
☐	005010X212	276 and 277	Claims status request and response
☐	005010X218	820	Group premium payments (*not available to all provider types*)
☐	Pharmacy 340B file		Pharmacy 340B file

***Section 6: Trading Partner Signature –** By signing below, the Trading Partner certifies the following:

- I have read the Electronic Data Transmission Oregon Administrative Rules (Chapter 943, Division 120) at Secretary of State OAR rules website, and understand my responsibilities as stated in these rules.
- I authorize OHA to transmit to the EDI Submitter listed in Section four (4) of this form the return computer file electronic vouchers of all transactions I have marked in Section five (5) of this form.

***Business name:** (from Section 1 of this form)	
*Email address: (individual, not a group)	
*Phone number with extension:	

*Authorized signer's printed name: (person listed in Section1) _____

*Authorized signer signature: _____ Signature date: _____

Form Section

EDI Submitter Information

***Section 7: EDI submitter information –** This page is to be completed and signed by the submitter or Clearinghouse that is chosen by the Medicaid provider. (Section 4 – page 2)			
***Submitter business name:**		EDI mailbox number:	MB000 _ _ _

***Submitter business contact name:**	
*Phone number with extension:	
*Email address: (individual, not group)	

***Submitter technical contact name:**	
*Phone number with extension:	
*Email address: (individual, not group)	

Section 8: EDI submitter required signature – By signing below, the EDI submitter certifies the following:

- I have read the Electric Data Transmission Oregon Administrative Rules (Chapter 943, Division 120) at Secretary of State OAR rules website, and understand my responsibilities as stated in these rules.
- I agree to protect the confidentiality of the data as required by law.

***Submitter business name:** (listed in Section 7)	
*Phone number with extension:	
*Email address: (individual, not group)	

*Authorized signer's printed name: (person listed in Section 7) _____

*Authorized signer signature: _____ Signature date: _____

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You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact EDI support at dhs.edisupport@odhsoha.oregon.gov or 1-844-882-7889. We accept all relay calls.