

*Trading Partner's National Provider Identifier (NPI): <hr/> *List all taxonomy code(s) registered to this NPI: <hr/> *List the Oregon Medicaid ID(s) associated with this NPI: <hr/>

Trading Partner Agreement for Electronic Health Care Transactions

When to complete this form: 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:

- **If you need to exchange transactions for more than one NPI**, complete a TPA for each NPI.
- **If you need to exchange transactions for multiple Oregon Medicaid ID numbers**, you can use one TPA but only if all locations need the same transactions.
- **If you need to authorize more than one clearinghouse/submitter**, complete a TPA for each one.
- **Please type or print clearly. Fill in all required fields designated with an asterisk (*).** Incomplete forms will NOT be processed.
- Please maintain a copy for your records.
- **Mail the completed form to:** EDI Support Services, 500 Summer St NE, E44, Salem, OR 97301.

Questions? Email DHS.EDISupport@state.or.us.

This TPA (<i>select one</i>): <input type="checkbox"/> Fully replaces the current TPA on file. This TPA will end all previous provider/submitter combinations registered under your Oregon Medicaid ID. <input type="checkbox"/> Adds information to the current TPA(s).	
ONE	Trading partner information – This cannot be a billing service.
	*Type (<i>select one</i>): <input type="checkbox"/> Provider <input type="checkbox"/> Clinic <input type="checkbox"/> Coordinated Care or Managed Care Organization
	*Business name (<i>as enrolled with OHA</i>): _____
	*Physical address: _____
	*City, state and ZIP: _____
*Phone number/extension: _____	
TWO	Trading partner authorized signer information – The primary signer signs Part 7 of this form.
	*Primary signer's name: _____
	*Phone number/extension: _____ *Title: _____
	*Email address (<i>direct, not group, email</i>): _____
	Secondary signer's name: _____
Phone number/extension: _____ Title: _____	
Email address (<i>direct, not group, email</i>): _____	
THREE	Claims contact information – This contact must be a person, not a group.
	*Primary contact's name: _____
	*Phone number/extension: _____ *Email address: _____
	Secondary contact's name: _____
	Phone number/extension: _____ *Email address: _____
FOUR	EDI submitter information – If your company intends to exchange transactions directly with OHA, enter "Self" as the submitter name, and enter your company's EDI contact information. If your company intends to use a submitter/clearinghouse, complete this section for the submitter/clearinghouse.
	*Submitter name: _____
	*Address: _____
	*City, state and ZIP: _____
	Submitter mailbox # : MB000

FIVE	EDI submitter's contact information – The Business Contact signs Part 8 of this form. OHA will email the Technical Contact when transaction testing is needed. Do not enter a billing service contact as the Technical Contact.	
	*Business contact's name: _____	
	*Phone number/extension: _____	
	*Email address (<i>direct, not group, email</i>): _____	
	*Technical contact's name: _____	
	*Phone number/extension: _____	<input type="checkbox"/> Third contact on reverse (<i>if needed</i>)
	*Email address (<i>direct, not group, email</i>): _____	

SIX	Authorized transactions – Check all transactions that OHA should authorize for your EDI submitter.	
	HIPAA 5010A1 transactions for: <input type="checkbox"/> FFS provider or <input type="checkbox"/> CCO/MCO	
	<input type="checkbox"/> 005010X222A1 837P	Professional Claim Submission
	<input type="checkbox"/> 005010X224A2 837D	Dental Claim Submission
	<input type="checkbox"/> 005010X223A2 837I	Institutional Claim Submission
	<input type="checkbox"/> 005010X221A1 835	Electronic Remittance Advice
	<input type="checkbox"/> 005010X279A1 270 and 271:	<input type="checkbox"/> Batch <input type="checkbox"/> Real-time Eligibility Benefits Inquiry and Response
	<input type="checkbox"/> 005010X212 276 and 277:	<input type="checkbox"/> Batch <input type="checkbox"/> Real-time Claims Status Request and Response
	<input type="checkbox"/> 005010X218 820	Group Premium Payments
	<input type="checkbox"/> 005010X220A1 834	Benefit Enrollment and Maintenance (CCO/MCO only)
	<input type="checkbox"/> NCPDP 1.2/D.0	Request and Response (B1, B2, B3) (CCO/MCO only)
	<input type="checkbox"/> Pharmacy	Rx Carve-Out File (CCO/MCO only)
<input type="checkbox"/> Status file	CCO Status File (CCO/MCO only)	

SEVEN	Trading Partner signature – By signing below, the Trading Partner certifies the following:	
	<ul style="list-style-type: none"> I have read the Electronic Data Transmission Oregon Administrative Rules (Chapter 943, Division 120) at http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html, and understand my responsibilities as stated in these rules. I authorize OHA to transmit to the <i>EDI Submitter</i> listed in Part 4 of this form the return computer file electronic vouchers of all transactions I have marked in Part 6 of this form. 	
	*Provider, clinic, CCO or MCO name (<i>from Part 1 of this form</i>): _____	*Email address: _____
	*Authorized trading partner signature: _____	*Phone number/extension: _____
		*Date: _____
	<i>Original signature only, of the Primary Signer listed in Part 2</i>	

EIGHT	EDI Submitter signature – By signing below, the EDI Submitter certifies the following:	
	<ul style="list-style-type: none"> I have read the Electronic Data Transmission Oregon Administrative Rules (Chapter 943, Division 120) at http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html, and understand my responsibilities as stated in these rules. I agree to protect the confidentiality of the data as required by law. 	
	*Business contact name (<i>from Part 5 of this form</i>): _____	*Email address: _____
	*Authorized EDI submitter signature: _____	*Phone number/extension: _____
		*Date: _____
	<i>Original signature only, of the Business Contact listed in Part 5</i>	