



Electronic Data Interchange Transaction Request Form

Section 1: Options

I would like to: New EDI Enrollment

Change: Clearinghouse Billing Service Billing Office Direct Submitter

Section 2: Office/Submitter Profile

Office Name: _____

Address: _____

City, State, Zip: _____

Phone: () _____ Ext: _____ Fax: () _____

Contact Name: _____

Email: _____

Provider / Group Profile

Name of Physician, Degree Hospital, or Group	Tax ID	NPI

Please attach additional providers if necessary.

Fax the completed form to 970-244-7880; Attention: IT/EDI.

Section 3: Electronic Claims Transmittal Report Contact

If data will be submitted to RHMP by a party other than the office, such as a clearinghouse or billing office, please specify below. Failure to specify a clearinghouse or billing office when applicable may result in incorrect EDI set-up and/or delay in EDI transmission to RMHP.

Office Name: _____

Address: _____

City, State, Zip: _____

Phone: () _____ Ext: _____ Fax: () _____

E-Mail: _____

Contact Name: _____

Section 4: Inbound and Outbound Transmission Information

Please indicate which transaction type(s) you will be submitting:

Inbound 837P 837I

Please indicate if you wish to receive these outbound transmissions:

Outbound 835

997 Acknowledgement Yes No

