ELECTRONIC DATA INTERCHANGE (EDI) TRADING PARTNER PROFLE – PROVIDER

State Form 51401 (R1-08) / Part of State Publication 286
Indiana State Department of Health

Indiana State Department of Health
Office of HIPAA Compliance
EDI Division 3K
2 North Meridian Street
Indianapolis, IN 46204 – 3010
(317) 233-9803

Provider of Service:

Name

_____

Address (*include suite*) _____

City _____ State _____ ZIP + 4 _____

Contact Name

_____

Telephone number _____ Fax number_____

E-Mail _____

Software Vendor Information:

(Providers, please complete this section if you are currently working with any Software vendor)
Please list all Software Vendor(*s*) used for submission of Medical, Dental, Vision, and Pharmacy electronic claims.

Software Vendor 1:

☐ X12 ☐ NCPDP V5.1

Name

_____

Address (*include suite*): _____

City _____ State _____ ZIP + 4 _____

Contact Name

_____

Telephone number _____ Fax number_____

E-Mail _____

Software Vendor 2:

☐ X12 ☐ NCPDP V5.1

Name

_____

Address (*include suite*) _____

City _____ State _____ ZIP + 4 _____

Contact Name

_____

Telephone number _____ Fax number_____

E-Mail _____

Clearinghouse Information:

(*Providers, please complete this section if you are currently working with any clearinghouse / switch to submit transactions to the Indiana State Department of Health)*
Please list all Clearinghouse(*s*) used for submission of Medical, Dental, Vision, and Pharmacy electronic claims.

Clearinghouse 1:

☐ X12 ☐ NCPDP V5.1

Name

_____

Address (*include suite*) _____

City _____ State _____ ZIP + 4 _____

Contact Name

_____

Telephone number _____ Fax number_____

E-Mail _____

Clearinghouse 2:

☐ X12 ☐ NCPDP V5.1

Name

_____

Address (*include suite*) _____

City _____ State _____ ZIP + 4 _____

Contact Name

_____

Telephone number _____ Fax number_____

E-Mail _____

Indicate your request(s) for the EDI transactions below

Inbound (*sent from you to ISDH*):

- ☐ Health Care Claim (*837*)
- ☐ Prior Authorization (*278*)
- ☐ Eligibility Request (*270*)
- ☐ Claim Status Request (*276*)
- ☐ Prior Authorization (*NCPDP P1-P4*)
- ☐ Billing / Reversal (*NCPDP B1, B2*)
- ☐ Re-bill (*NCPDP B3*)
- ☐ Eligibility Verification (*NCPDP E1*)

Outbound (*sent from ISDH to you*):

- ☐ Payment Advice (*835*)
- ☐ Prior Authorization (*278*)
- ☐ Eligibility Request (*271*)
- ☐ Claim Status Request (*277*)
- ☐ Response (*NCPDP B1, B2*)

Remittance Advices are provided twice weekly include claims submitted electronically and on paper.

Data Transmission / Retrieval Method
(please complete if you will be submitting transactions directly from your office to Indiana State Department of Health):

- ☐ Asynchronous Dial-up
- ☐ Secure FTP (*planned for future use*)
- ☐ Side by Side VPN connection

I am authorizing the outbound transactions indicated to be retrieved by:

- ☐ Provider of Service
- ☐ Software Vendor /Third party vendor
- ☐ Clearinghouse / Switch

Authorized Signature _____

Title of Authorized Signatory _____

Date (*mm/dd/yyyy*)_____