eSolutions
Strengthen your revenue health
EDI Insight

Payer ID: MCDOR/SKOR0

Oregon Medicaid
837I

EDI Enrollment Instructions:

- The billing provider must have an EDIinsight customer account.
- SAVE Pages 2-4 of this document to your computer.
- OPEN the file in Adobe Reader program and type directly onto the form.
- Complete the forms using the Billing/Group provider number as credentialed with Oregon Medicaid.
- Please note: all signatures must be signed in **BLUE** ink.
- Acceptable signatures:
  --For solo practices, the signature must be that of the provider.
  --For a group or corporation, the signature must be that of the president, CEO or owner.
- PRINT, SIGN and SCAN or SAVE the form to your PC so that you may submit the form to the EDIinsight Enrollment Team using EDIinsight Enrollment Manager.
- ERA enrollment processing timeframe is approximately 30 days.
- Support Vendors may contact the EDIinsight Enrollment Team to follow up on the EDI setup request. Or, the provider may contact Medicaid at dhs.edisupport@state.or.us.

837 Claims Transactions and 835 Remittance Advice:

Trading Partner Agreement (TPA) for Electronic Health Care Transactions (4 pages)

On Page 1, enter all applicable Taxonomy codes.

Complete Section 2 on Page 1 by entering the Primary authorized signer’s contact information.

Complete Section 3 on Page 2 by entering the Primary claims contact information.

Please note: This must be different than the individual entered in Section 2.

The individual whose information was listed in Section 2 must print their name, date and sign under Section 6 on Page 3.

Submit to EDIinsight Enrollment Team:

Within EDIinsight - Enrollment Manager:
GO TO or **[ADD Payer Enrollment] record** for this payer.
SELECT record, CLICK **[ATTACH File]** to attach all pages of the completed payer form.
IF prompted, asking if you want to Submit the request, CLICK **[Yes]** -Or- CLICK **[SUBMIT Enrollment]**
ENTER any notes (optional)
CLICK to **"Save and Exit"** notes' window.

OREGON HEALTH AUTHORITY

Trading Partner Agreement (TPA) for Electronic Health Care Transactions

For form instructions, click here.

If you have further questions, email OHA.TPAgreements@odhsoha.oregon.gov.

Please make sure all sections marked with an asterisk (*) have been completed to avoid automatic denial.

Check this box if you are **only updating contacts.** Please leave section 5, 7 and 8 blank and complete the rest of the form.

National provider identifier (NPI)***:** ______________________

Medicaid ID*: ______________________

Taxonomy codes*: ______________________

Section 1: Medicaid provider information

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

Primary authorized signer's name*: ______________________

Title*: ______________________

Individual email address (**not** group email)*: ______________________

Phone number with extension*: ______________________

Secondary authorized signer's name: ______________________

Title: ______________________

Individual email address (**not** group email): ______________________

Phone number with extension: ______________________

Section 3: Trading partner claims contact information

Primary claims contact name*: ______________________

Individual email address (**not** group email)*: ______________________

Phone number with extension*: ______________________

Secondary claims contact name: ______________________

Individual email address (**not** group email): ______________________

Phone number with extension: ______________________

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 ______________________

Section 5: Authorized transactions

Check all transactions that OHA should authorize for your EDI submitter.

HIPAA 5010A1 transactions*:

Transaction	Description
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 Electric Data Transmission Oregon Administrative Rules (OAR) (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.

Primary authorized signer's printed name*: ____________________

Authorized signer's signature*: ____________________

Date*: ____________________

Section 7: EDI submitter information

Sections 7 and 8 are to be completed and signed by the submitter or Clearinghouse that is chosen by the Medicaid provider.

Submitter business contact name*: ____________________

Individual email address (**not** group email)*: ____________________

Phone number with extension*: ____________________

Submitter technical contact name*: ____________________

Individual email address (**not** group email)*: ____________________

Phone number with extension*: ____________________

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 (OAR) (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.

Primary authorized signer's printed name*: ____________________

Authorized signer's signature*: ____________________

Date*: ____________________

Email the completed form as a PDF document to:
OHA.TPAgreements@odhsoha.oregon.gov

Fax forms to (503) 945-5972.

If you cannot submit by email or fax, you can **mail forms to**:

EDI Support Services
ATTN: TPA Requests
500 Summer St NE E44
Salem, OR 97301

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact TPA Team at OHA.TPAgreements@odhsoha.oregon.gov or 503-378-3503. We accept all relay calls.

All general questions need to be submitted via **email. General question calls** will not be accepted.

Medicaid Division
EDI Support Services
500 Summer St NE E44
Salem, OR 97232

OHA.TPAgreements@odhsoha.oregon.gov