## MARYLAND MEDICAL CARE PROGRAMS SUBMITTER IDENTIFICATION FORM

For Version 005010 HIPAA Transaction Set

Maryland Medicaid needs some EDI information to exchange HIPAA transactions with you. Please provide the information below. If you are not processing your own EDI transactions, please have your Electronic Submitter assist you in completing this form, specifically with items #3 and #4.

Select Media if New Application:

<ul><li>New Application</li><li>Change of Submitter Agent</li><li>Submitter Identification Form Update</li></ul>	Selectronic Transfer & Paper Voucher     Selectronic Transfer & Paper Vou
2. Provider Information	
a) Provider Name:	
b) Provider Address:	
c) Provider Number (must be 9 digits):	
d) National Provider Identifier (NPI #)	
3. Electronic Submitter Information	
a) Submitter Name:	
b) Submitter Address:	
c) Submitter ID(ISA Qualifier and ISA ID):	

## 4. EDI Information

1. This is a

Please select the transactions that you want to exchange with Maryland Medicaid out of the following transactions:

CHECK	TRANSACTIONS	VERSION
	270/271 Eligibility Inquiry & Response	005010X279A1
	276/277 Claim Status & Response	005010X212
	837 Health Care Claim Institutional / 277CA Claim Acknowledgment	005010X223A2 / 005010X214X
	837 Health Care Claim Professional / 277CA Claim Acknowledgment	005010X222A1 / 005010X214X
	837 Health Care Claim Dental / 277CA Claim Acknowledgment	005010X224A2 / 005010X214X
	820 Premium Payment	005010X218
	835 Health Care Claim Payment/Advice 835 GS Receiver ID (Required, if Checked)	005010X221A1
	Receiver EDI Information (Required if different from above listed Submitter ID or if you are a Pharmacy Provider or Business Associate requesting an 835): Receiver Name: Receiver Address: ISA Qualifier and ISA ID:	

Submitter-Identification-Form-005010 Revised: 03/21/2012

## MARYLAND MEDICAL CARE PROGRAMS SUBMITTER IDENTIFICATION FORM

For Version 005010 HIPAA Transaction Set

The provider,	authorizes					
	PROVIDE	R NAME				
	, hereafter					
SUBMITTER	AGENT					
	<del></del> :		aryland Medical Care Program, and			
		=	<u>Submitter Agent</u> the return computer			
	ocessed. The	<u>Submitter Agent</u> agrees to	protect the confidentiality of this data			
as required by law.						
Signature of Provider		Signature of Submitter Agent				
Print Name of Signature		Print Name of Signature				
Telephone Number	Date	Telephone Number	Date			
Note: This form requires c processed.	ompletion of a	Il requested information and	d <u>original signatures</u> to be			
MAIL TO:						
SYSTEMS LIAISON SERVICES 201 W. PRESTON ST., RM SS-18 BALTIMORE, MD 21201 ATTN: HIPAA DESK						
For Internal Use Only: Systems Liaison Ser Date Received:	vices Signatı	ıre:				

Submitter-Identification-Form-005010 Revised: 03/21/2012