

**EDI Support Services**  
**PO Box 6729**  
**Fargo, ND 58108-6729**

The information you provide on this EDI registration is used to set your facility up for the 837 (Claim), 835 (Remittance Advice), or 276/277 (Claim Status Request) transaction. Complete the form and select the Print Form button. Once printed, obtain the appropriate signature and mail or fax to EDISS at 1-877-269-1472. All sections not greyed out must be completed or the form will not be processed.

1. Please select the appropriate choice.

Today's Date

- Changing existing EDI application     New EDI Application     Terminating existing EDI application

2. What date would you like number 1 to take effect?

3. Federal Tax ID: \_\_\_\_\_

4. Group/Billing NPI: \_\_\_\_\_

State: \_\_\_\_\_

5. Select the transaction this will be in effect for.

837 Health Care Claim

Select the line of business this is for 837:

- Medicare Part B
- Medicare Part A
- Medicare Part B Drugs and Biologicals (*for CAP vendors only*)
- Noridian Mutual Insurance Company (NMIC) Professional (*for Minnesota only*)
- Noridian Mutual Insurance Company (NMIC) Institutional (*for Minnesota only*)

835 Health Care Claim Payment/Advice

Deliver 835 to: \_\_\_\_\_

Receiver Name: \_\_\_\_\_

Select the line of business this is for 835:

- Medicare Part B
- Medicare Part A
- Medicare Part B Drugs and Biologicals (*for CAP vendors only*)
- Noridian Mutual Insurance Company (NMIC) Professional (*for Minnesota only*)
- Noridian Mutual Insurance Company (NMIC) Institutional (*for Minnesota only*)

276/277 Health Care Claim Status Request and Response

Deliver 277 to: \_\_\_\_\_

Receiver Name: \_\_\_\_\_

Select the line of business this is for 276:

- Medicare Part B
- Medicare Part A
- Medicare Part B Drugs and Biologicals (*for CAP vendors only*)
- Noridian Mutual Insurance Company (NMIC) Professional (*for Minnesota only*)
- Noridian Mutual Insurance Company (NMIC) Institutional (*for Minnesota only*)

6. Complete the information for the provider/clinic information.

Facility/Legal Business Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Contact:  Phone Number:   
 \*Email:  Fax Number:

\*By providing your e-mail address, you are authorizing EDISS to subscribe you to our e-mail distribution. This distribution includes important notifications for the provider and vendor community.

7. Who will submit your claims to EDISS? (check one and complete the Vendor Information for that entity)

- I will submit direct from my office to EDISS using the software indicated below.
- I will submit to the Billing Service indicated below who will then submit to EDISS on my behalf.
- I will submit to the Clearinghouse indicated below who will then submit to EDISS on my behalf.
- I will submit direct to EDISS using their free software (PC-ACE Pro32\*\*\*). *If this option is selected, complete a Software License Agreement (SLA)) Do not complete the Vendor Information.*

\*\*\*PC-ACE Pro32 is available to download free of charge from our website. EDISS requires a \$25.00 yearly fee from anybody requesting the PC-ACE Pro32 program on Compact Disc (CD). This fee will cover the shipping and handling of the software and its continuing updates. This fee is an annual fee allowed by the Centers for Medicare & Medicaid Services (CMS).

Vendor Information			
Vendor Name:	<input style="width: 100%;" type="text"/>		
Vendor Contact Name:	<input style="width: 20%;" type="text"/>	Software Product Name:	<input style="width: 60%;" type="text"/>
Phone Number:	<input style="width: 20%;" type="text"/>	Fax Number:	<input style="width: 60%;" type="text"/>

8. What is your method of electronic access?

EDISS by default will set you up with Zmodem protocol. If different please select the correct one. (Zmodem is most common)

9. Mail or fax the completed form, with an authorized signature, to EDISS.

As a member of this provider organization, I have the authority to enter into, administrate, and/or terminate contracts and make related determinations. By signing this document I verify I meet the signature requirements and authorize the set-up noted above.

Signature: \_\_\_\_\_

Type Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Use section below only under the direction of a customer service specialist: