

EDI TRADING PARTNER REGISTRATION FORM
Please print legibly to avoid form being returned

1. Trading Partner Information

Partner Name _____			Sender Number _____
Address _____			(if applicable)
City _____	State _____	Zip Code _____	
Contact Name _____			Phone _____
E-Mail Address _____			Fax _____

2. Type of Submitter *Check one*

Physician Clearinghouse Billing Service Software Vendor Hospital Lab

3. Transaction(s)

837I Claim: Institutional
 837P Claim: Professional
 837D Claim: Dental
 270/271 Eligibility
 276/277 Claim Status
 278 Referral Status
 *835 Payment Advice / Remit

4. State

SC Medicaid
 SC Medicaid
 SC Medicaid
 SC Medicaid
 SC Medicaid
 SC Medicaid
 SC Medicaid

5. Transmission Method *Check one*

Kermit
 Z Modem
 FTP via PPP Connection
 PK Zipped
 G Zipped

*Complete additional registration form, available on www.BlueChoiceSCMedicaid.com

6. Delimiters (preferred) Element Separator: asterisk (*) Sub-element Separator: bar (|) Segment Terminator: Tilde (~)
Specify Element Separator: _____ Sub-element Separator: _____ Segment Terminator: _____

7. Technical Information

Vendor Name _____			
Address _____			
City _____	State _____	Zip Code _____	
Contact Name _____			Phone _____
E-Mail Address _____			Fax _____
Software Name _____			

DATABASE ID	SENDER ID	MERCATOR	FTP REQUEST	
SET UP DATE	PASSWORD	UNIX	STATE	
	PROV LOOKUP	SERVICE CENTER		OFFICE USE ONLY

COMPLETED REGISTRATION FORM MUST BE RETURNED VIA MAIL OR FAX TO:

EDI Solutions
13550 Triton Park Blvd.
Louisville, KY 40223
Phone: 800-470-9630 Fax: 866-480-4916

BY COMPLETING THE EDI REGISTRATION FORM, I ACKNOWLEDGE THE RECEIPT OF THE TRADING PARTNER AGREEMENT AND USER GUIDE/COMPANION DOCUMENTS.

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