

WHICH FORMS SHOULD I COMPLETE?

- Complete the **Ohio Department of Medicaid – Designation of an 835 Trading Partner** (Page 2)

WHERE SHOULD I SEND THE FORM(S)?

- You can submit the form by:
 - o Emailing it to omesedisupport@medicaid.ohio.gov
OR
 - o Mailing it to
Ohio Department of Medicaid
MCD-EDI Support
PO Box 182709
Columbus, OH 43218-2709

WHAT IS THE TURNAROUND TIME?

- Standard processing time is 7-14 Business Days

HOW DO I CHECK STATUS?

- Send an email to omesedisupport@medicaid.ohio.gov and ask if you have been linked to Office Ally's TPID **0018466** for ERAs.

DESIGNATION OF AN 835 TRADING PARTNER

By completing and signing this form the provider authorizes the department to transmit remittance advice data in an X12-5010 format through the EDI Trading Partner listed in Section II of this form. **All fields with an (*) are required.** Forms missing required information will not be processed. Please include information in other fields if it is available. **Current date will be used if the Effective Date is not included.**

SECTION I: PROVIDER INFORMATION

Provider Name:*	Doing Business as Name (DBA):		
Street:*			
City:*	State/Province:*	ZIP Code/Postal Code:*	

SECTION II: PROVIDER IDENTIFIERS INFORMATION

Provider Identifiers	Provider Federal Tax Identification Number (TIN)	National Provider Identifier (NPI):
	or Employer Identification Number (EIN):*	Medicaid Provider ID:*
Other Identifiers	Assigning Authority: Ohio Department of Medicaid	Trading Partner ID:*
		0018466

SECTION III: PROVIDER CONTACT INFORMATION

Provider Contact Name:*	Title:		
Telephone Number:*	Extension	Email Address:*	Fax Number:

SECTION IV: ELECTRONIC REMITTANCE ADVICE INFORMATION

PREFERENCE FOR AGGREGATION OF REMITTANCE DATA	
<i>Provider Preference for grouping (bulking) claim payment remittance advice.</i>	
Provider Tax Identification Number (TIN): <i>Required if NPI is not applicable*</i>	National Provider Identifier (NPI): <i>Required if TIN is not applicable*</i>

SECTION V: ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

Clearinghouse Name:*	Clearinghouse Contact Name:*
Office Ally	Payer Enrollment
Telephone Number: 360-975-7000	Email Address: PayerEnrollment@officeally.com

SECTION VI: SUBMISSION INFORMATION

Reason for Submission:*	Requested ERA Effective Date:
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Enrollment <input type="checkbox"/> Cancel Enrollment	

AUTHORIZED SIGNATURE

The signature of an individual authorized by the provider or its agent to initiate, modify, or terminate an enrollment.

Written Signature of Person Submitting Enrollment:*
Printed Name of Person Submitting Enrollment:*
Printed Title of Person Submitting Enrollment:

Send the completed form to

Ohio Department of Medicaid
MCD-EDI Support
P.O. Box 182709
Columbus, Ohio 43218-2709

Or eMail: omesedisupport@medicaid.ohio.gov