MARYLAND MEDICAL CARE PROGRAMS
SUBMITTER IDENTIFICATION FORM
For Version 004010 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.

1. This is a
   [ ] New Application
   [ ] Change of Submitter Agent
   [ ] Submitter Identification Form Update

Select Media if New Application:
[ ] Electronic Transfer & Paper Voucher
[ ] Paper Voucher Only

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**
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	004010X092A1
	276/277 Claim Status & Response	004010X093A1
	837 Health Care Claim Institutional	004010X096A1
	837 Health Care Claim Professional	004010X098A1
	837 Health Care Claim Dental	004010X097A1
	820 Premium Payment	004010X061A1
	835 Health Care Claim Payment/Advice **835 GS Receiver ID** _____ (**Required, if Checked**) 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**:**	004010X091A1

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The provider, _____ hereby authorizes
PROVIDER NAME
_____, hereafter
SUBMITTER AGENT
referred to as *Submitter Agent*, to transmit our Medicaid claims to Maryland Medical Care Program, and further authorizes Maryland Medical Care Program to transmit to the *Submitter Agent* the return computer file electronic vouchers of all claims data processed, indicating paid, rejected, denied and pended claims (with error codes). The *Submitter Agent* 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 completion of all requested information and **original signatures** to be processed.

MAIL TO:

SYSTEM LIAISON SERVICES
201 W. PRESTON ST., RM SS-18
BALTIMORE, MD 21201
ATTN: HIPAA DESK

For Internal Use Only:

Systems Liaison Services Signature: _____

Date Received: _____