

All Noridian Carriers

Provider Transaction Termination/Change Form

Complete form, sign and mail original to:
Noridian Administrative Services, LLC (NAS)
EDI Support Services
PO Box 9319
Fargo, ND 58106-9319

Blank forms may be copied.


Call LTC at 888-941-8967 if you have questions.

Provider Transaction Termination/Change Form Completion Instructions

EDI Support Services (EDISS) uses the information you provide on this Provider Transaction Termination/Change form to remove and/or modify your existing information record for an electronic transaction. The provider should complete this form for the following reasons: 1) To inform EDISS that his/her billing provider/clinic number has been terminated, 2) To discontinue submission of an electronic transaction, 3) To update address information, 4) To change to direct submission or to change utilization of a billing service, clearinghouse, or software vendor, 5) To change the recipient of the provider's Electronic Remittance Advice (ERA). **Do not** use this form to register for sending electronic transactions. Register for sending electronic transactions by filling out the appropriate Exhibit A registration form corresponding to that transaction. **Print legibly and complete every section as accurately as possible.**

If a section does not apply, write "N/A".

If you have any additional questions, contact EDISS at (800) 967-7902.

 **DO NOT** utilize this form if you are currently registered with EDISS and have received your 10 digit National Provider Identifier (NPI). Please submit the "NPI Update Request Form" in place of this Exhibit A. If you have any questions about which form to complete, please contact EDISS at (800) 967-7902.

FORM OBJECTIVE

1. Check all boxes that apply as long as the changes pertain to one Transaction Type indicated in #5. EDISS requires a Provider Transaction Termination/Change form for each transaction that is affected. For example, if a provider intends to inform EDISS that he/she has changed from direct submission to utilizing a vendor that will be submitting the provider's 837 Professional Claims transactions and the provider's 276/277 Claim Status/Response transactions, the provider would need to complete two Provider Transaction Termination/Change forms - one for the 837 Professional Claims transaction and one for the 276/277 Claim Status/Response transaction.

CURRENT PROVIDER INFORMATION

2. The current legal business provider/facility name and corresponding contact information is **required**.
3. The Federal Tax ID of the provider is **required**. If the Federal Tax ID number is changing, **STOP! The following steps need to be taken:**
 - A change in Federal Tax ID requires a new billing provider/clinic number. Contact the appropriate enrollment office for assistance.
 - Upon receipt of the new billing provider/clinic number, use this form to terminate the old billing provider/clinic number for the applicable electronic transaction. Separate Provider Transaction Termination/Change forms must be completed if multiple electronic transactions need to be terminated.
 - Fill out the Exhibit A registration forms corresponding to the electronic transactions that will use the new number. The Exhibit A registration forms are available at www.noridianmedicare.com. Testing with EDISS may be necessary.
4. The date indicating when the provider will be ready to terminate/change the information noted is **required**. This date is of particular importance for providers that are changing to a new submission method. For example, if a provider intends to change vendors (i.e. billing services or clearinghouses), the provider must indicate the date that EDISS should prohibit the old vendor from submitting the provider's transaction and allow the new vendor to submit on the provider's behalf. **Note:** If the effective date is not indicated, EDISS will process this Provider Transaction Termination/Change form within EDISS' standard processing time frame.
5. The Transaction Type to which the Provider Transaction Termination/Change form applies is **required**. Check only **one**. If the change applies to multiple transactions, complete a Provider Transaction Termination/Change form for each transaction.
6. The Line(s) of Business (LOB) for the Transaction Type selected in #5 is **required**. Fill in the corresponding billing provider/clinic number on file with EDISS in the blank provided. **Note:** For group practices, fill in the group number.
7. The Submitter ID for the Transaction Type in #5 and the LOB listed in #6 (e.g. "ND00123").

BILLING PROVIDER/CLINIC NUMBER TERMINATION NOTIFICATION

8. Complete the section to notify EDISS of the billing provider number/clinic number(s) that the provider has terminated for the Transaction Type in #5 and the LOB listed in #6. **Note:** EDISS does not terminate billing provider/clinic numbers. When a provider completes the Provider Transaction Termination/Change form to notify EDISS that his/her billing provider/clinic number has been terminated, EDISS changes its records so that electronic transactions cannot be submitted for that terminated billing provider/clinic number. To terminate a billing provider/clinic number, the provider must contact the provider enrollment office for assistance.

Provider Transaction Termination/Change Form Completion Instructions (continued)

CHANGE IN FACILITY INFORMATION NOTIFICATION

9. Complete this section with the requested information for the provider/clinic to indicate the change(s) in the facility information. If the change in facility information corresponds to a change in Federal Tax ID, **STOP!**

The following steps need to be taken:

- A change in Federal Tax ID requires a new billing provider number. Contact the appropriate provider enrollment office for assistance.
- Upon receipt of the new billing provider number, use this form to terminate the old billing provider number's Trading Partner/Submitter ID for the applicable electronic transaction. Separate Provider Transaction Termination/Change forms must be completed if multiple transactions need to be terminated.

Fill out the Exhibit A registration forms corresponding to the electronic transactions that will use the new number. The Exhibit A registration forms are available at www.noridianmedicare.com. Testing with EDISS may be necessary.

CHANGE IN SUBMISSION METHOD INFORMATION

10. Complete this section only if you are changing the method you use to send claims to Noridian EDISS. Changing to a new software vendor, billing service, or clearinghouse are examples of a change in submission method.

- Check only one box.
- Complete the section with the new vendor name and software product name.

Note: If changing to PC-ACE Pro32, EDISS's low-cost billing software solution, you must fill out the Software License Agreement available on the EDISS website at www.noridianmedicare.com.

- Complete the section with the new contact information.


CHANGE IN ELECTRONIC REMITTANCE ADVICE INFORMATION (835)

11. Providers who are receiving an 835 ERA and would like to **change** the receiver of the 835 are instructed to provide the facility name and Trading Partner ID of the entity to receive the 835. An 835 Health Care Claim Payment/Advice Exhibit A Registration form is **not** required. If providers intend to receive an Electronic Remittance Advice (ERA) but have not yet registered this transaction with EDI, **STOP!** An 835 Health Care Claim Payment/Advice Exhibit A Registration form is **required**. The 835 Health Care Claim Payment/Advice Exhibit A Registration form can be found on our website at www.noridianmedicare.com.

ORIGINAL SIGNATURE

12. The signature section needs to be filled out and signed in ink by the provider. If the provider's signature is not available, a signature of someone from the facility holding a management position or higher will be accepted. If the provider/facility has been assigned a group provider/clinic number, EDISS requires the signature of the individual who has the authority to enter into contracts on behalf of the group. **The form with an original ink signature must be mailed to EDISS.**

Provider Transaction Term/Change Form

PROVIDER TRANSACTION TERMINATION/CHANGE FORM	
Noridian Administrative Services, LLC (NAS) EDI Support Services PO Box 9319 Fargo, ND 58106-9319	Phone number: (800) 967-7902 Contact us via e-mail at: edi@noridian.com Visit our website at: www.noridianmedicare.com

EDI Support Services (EDISS) uses the information you provide on this Provider Transaction Termination/Change form to remove and/or modify your existing information record for an electronic transaction. The provider should complete this form for the following reasons: 1) To inform EDISS that his/her billing provider/clinic number has been terminated, 2) To discontinue submission of an electronic transaction, 3) To update address information, 4) To change to direct submission or to change billing service, clearinghouse, or software vendor information, 5) To change the recipient of Electronic Remittance Advice (ERA). Do not use this form to register for sending electronic transactions. Register for electronic transactions by filling out the appropriate Exhibit A registration form corresponding to that transaction. Print legibly and complete every section as accurately as possible.

If a section does not apply, write "N/A".

If you have any questions concerning the correct completion of the form, contact EDI Support Services (EDISS) at (800) 967-7902.

FORM OBJECTIVE

- Specify the intention of the form by checking all boxes that apply. Then, fill out the corresponding numbers on the form.
 - I wish to inform EDISS of a billing provider/clinic number that has been terminated. Fill out 1-7, 8, 12.
 - I wish to discontinue submission of a transaction. **Note:** Only one transaction termination is allowed per form. Fill out 1-7, 12.
 - I wish to update existing facility information. Fill out 1-7, 9, 12.
 - I wish to change to direct submission or change vendors. Fill out 1-7, 10, 12.
 - I wish to change the receiver of my ERA. Fill out 1-7, 11-12.

CURRENT PROVIDER INFORMATION

2. **Provider/Facility Name:** _____

Contact Name: _____

Telephone: () _____ **Fax:** () _____

3. **Federal Tax ID:** _____

4. **Request a date that the termination/change should be made:** ____/____/____

Note: If the effective date is not indicated, the change indicated on the form will be processed within EDISS's standard processing time frame and may impact claim processing when a change in submission status is involved (refer to the Form Completion Instructions).

5. **Select the Transaction Type to which this termination/change form applies. (check one)**

Note: Check only **one** Transaction type. If the change applies to multiple transactions, complete a Provider Transaction Termination/Change form for each transaction (refer to the Form Completion Instructions).

- | | |
|---|---|
| <input type="checkbox"/> 835 - Health Care Claim Payment/Advice (ERA) | <input type="checkbox"/> 270/271 - Health Care Eligibility/Benefit Inquiry and Response |
| <input type="checkbox"/> 837D - Dental Claims | <input type="checkbox"/> 276/277 - Health Care Claim Status Request and Response |
| <input type="checkbox"/> 837I - Institutional Claims | <input type="checkbox"/> 278 - Authorization Request and Response |
| <input type="checkbox"/> 837P - Professional Claims | |

Provider Transaction Term/Change Form

CURRENT PROVIDER INFORMATION (continued)

6. Select the Line of Business for the transaction type indicated in #5 and fill out the **corresponding** billing provider or clinic number on file with EDISS in the blank provided. *(check and fill out all that apply)*

- Blue Cross _____
- Blue Shield _____
- Dental Services Corporation of North Dakota (DSC) _____
- Iowa Medicaid _____
- Medicare A _____
- Medicare B _____
- North Dakota Medicaid _____
- North Dakota Workforce Safety & Insurance _____
- North Dakota Vision Services, Inc. _____
- TriWest (TriCare) (Federal Tax ID) _____
- Medicare Advantage Essential Hospital _____

7. For the Transaction Type indicated in #5 and LOB indicated in #6, fill out the following:

Submitter ID: _____

BILLING PROVIDER/CLINIC NUMBER TERMINATION NOTIFICATION

8. Complete this section to notify EDISS of the terminated billing provider/clinic number for the appropriate line(s) of business listed below.

Professional Lines of Business

- Blue Shield _____
- Dental Services Corporation of North Dakota (DSC) _____
- Iowa Medicaid _____
- Medicare B _____
- North Dakota Medicaid _____
- North Dakota Workforce Safety & Insurance _____
- North Dakota Vision Services, Inc. _____
- TriWest (TriCare) (Federal Tax ID) _____

Note: A separate form must be completed if terminating an Institutional billing provider/clinic number.

Institutional Lines of Business

- Blue Cross _____
- Iowa Medicaid _____
- Medicare A _____
- North Dakota Medicaid _____
- North Dakota Workforce Safety & Insurance _____
- TriWest (TriCare) (Federal Tax ID) _____
- Medicare Advantage Essential Hospital _____

Note: A separate form must be completed if terminating a Professional billing provider/clinic number.

Provider Transaction Term/Change Form

CHANGE IN FACILITY INFORMATION

9. Fill in all of the blanks with the requested information for the provider/clinic to indicate a change in facility information.

Previous Facility Information:

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Contact: _____

Telephone: () _____

Fax: () _____

E-Mail: _____

Updated Facility Information:

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Contact: _____

Telephone: () _____

Fax: () _____

E-Mail: _____

CHANGE IN SUBMISSION METHOD INFORMATION

10. Changing to a new (*check one*): Software Vendor Billing Service Clearinghouse

New Submission Vendor Name: _____

New Software Product Name*: _____

*If changing to PC-ACE Pro32, a Software License Agreement must be completed.

New Vendor Contact: _____

Telephone: () _____ Fax: () _____

CHANGE IN ELECTRONIC REMITTANCE ADVICE INFORMATION (835)

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Receiver Name: _____

Trading Partner ID: _____

ORIGINAL SIGNATURE

12. An appropriate original ink signature (refer to the Form Completion Instructions) is required for this document. Blue ink is preferred. **The form with an original ink signature must be mailed to EDISS to avoid any interruptions in your ability to exchange data with EDISS.**

As a member of this organization, I am authorized to sign this document on behalf of the provider/facility, and I authorize the set-up noted above.

Signature: _____

Print name: _____

Title: _____

Date: _____ / _____ / _____