CGS EDI APPLICATION

Date:

Line of Business/ Payor ID: ☐ KY Part A 15101 ☐ KY Part B 15102 ☐ OH Part A 15201 ☐ OH Part B 15202 ☒ HHH 15004

Action Requested: ☒ Add Provider(s) ☐ Change/Update Submitter Information ☐ Delete ☐ Apply for New Submitter ID

Submitter ID (if available): CH15000020

Owner Name: Office Ally

Type of Submitter: ☐ Software Vendor ☐ Billing Service ☐ Provider ☒ Clearinghouse

EDI Contact Person: Customer Service

Phone: 360-975-7000 Option 1 **Fax:** 360-896-2151

Address: PO Box 872020

City: Vancouver **State:** WA **Zip:** 98687

Submitter Email Address (**Note:** E-mail will be the primary method of communication.): support@officeally.com

Data Compression: ☐ Uncompressed (GPNet Default) ☒ PKZIP ☐ UNIX-Compress

Name of Software Vendor: **Vendor Security ID:**

Network Service Vendor: ECC

Providers for Whom Submitter Will Be Transmitting:

Group Practice/Provider Name:

Provider Contact Name:

Provider E-mail Address:

Group Provider Number: **Group NPI:**

TIN/EIN number :

Provider Authorization Form Attached? ☐ Yes ☐ No

☒ Submit Claims ☒ Receive Reports ☐ Receive Electronic Remittances ☐ Online Inquiry Services

FAX completed form (for faster service) to:
- 1.615.664.5945 - Ohio Part A
- 1.615.664.5943 - Kentucky Part A
- 1.615.664.5947 - Home Health & Hospice
- 1.615.664.5927 - Ohio Part B
- 1.615.664.5917 - Kentucky Part B

Or mail completed form to: J15 - Part B Correspondence
CGS
PO Box 20018
Nashville, TN 37202

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

CGS EDI APPLICATION Multiple Providers List

Date: ____________

Providers for Whom Submitter Will Be Transmitting:

Group Practice/Provider Name: ____________

Provider E-mail Address: ____________

Group Provider Number: ____________ **Group NPI:** ____________

Provider Authorization Form Attached? ☐ Yes ☐ No

☐ Submit Claims ☐ Receive Reports ☐ Receive Electronic Remittances ☐ Online Inquiry Services

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Group Practice/Provider Name: ____________

Provider E-mail Address: ____________

Group Provider Number: ____________ **Group NPI:** ____________

Provider Authorization Form Attached? ☐ Yes ☐ No

☐ Submit Claims ☐ Receive Reports ☐ Receive Electronic Remittances ☐ Online Inquiry Services

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Group Practice/Provider Name: ____________

Provider E-mail Address: ____________

Group Provider Number: ____________ **Group NPI:** ____________

Provider Authorization Form Attached? ☐ Yes ☐ No

☐ Submit Claims ☐ Receive Reports ☐ Receive Electronic Remittances ☐ Online Inquiry Services

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Group Practice/Provider Name: ____________

Provider E-mail Address: ____________

Group Provider Number: ____________ **Group NPI:** ____________

Provider Authorization Form Attached? ☐ Yes ☐ No

☐ Submit Claims ☐ Receive Reports ☐ Receive Electronic Remittances ☐ Online Inquiry Services

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