


Exhibit A Trading Partner #: _____ (completed by EDI Support Services)

Submitter #: _____ (completed by EDI Support Services)

<p align="center">PROFESSIONAL (837P) CLAIM REGISTRATION</p>	
<p align="center">Noridian Administrative Services, LLC EDI Support Services PO Box 9319 Fargo, ND 58106-9319</p>	<p align="center">Phone number: 800-967-7902 Our fax number is 701-277-2196 Contact us via e-mail at: hipaa_edi@noridian.com Visit our website www.noridianmedicare.com</p>

The information you provide on this EDI registration is used to set up your office for electronic 837 professional claims submission. **Please complete every section as accurately and thoroughly as possible.** If a section is not applicable, write "N/A". If you have any questions concerning the correct completion of the form, please contact us for assistance. Once you are approved for EDI production status, notify us by using the Electronic Claims Termination/Change Form whenever this information changes.

PROVIDER INFORMATION

1. What date would you like to start testing your electronic professional claims transactions based on the information stated below? / /
2. Federal Tax ID/SSN: _____
3. Please select all lines of business that apply. Then fill in the blank with the appropriate clinic number or billing provider number.

Lines of Business (check all that apply)

- Blue Shield – North Dakota
- Blue Shield - Wyoming
- North Dakota Vision Services, Incorporated (VSI)

Clinic Number

Lines of Business (check all that apply)

- Medicare B – Iowa
- Medicare B – Midwest (ND, SD, CO, WY)
- Medicare B – Northwest (WA, OR, AK)
- Medicare B – Southwest (AZ, NV, HI)
- Noridian Health Plans
- Medicaid -North Dakota
- Workers Compensation - North Dakota

Billing Provider Number

4. The facility information should indicate the actual information of the clinic/doctor that the claims will be billed for.

Facility Information

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Contact: _____

Telephone: () _____ Fax : () _____

E-Mail : _____

5. Please fill out the applicable sections:

Software Vendor Information

Vendor Name : _____

Software Product Name: _____

Billing Service Information

Facility Name : _____

Software Product Name: _____

Clearinghouse Information

Facility Name : _____

Software Product Name: _____

6.

- Do you want to receive your remittance advice (ERA) electronically?
*An ERA is an electronic copy of the payment data received on the paper remittance
You must have a software program to print or post this data.*
 Yes No *(if yes, fill out the 835 Health Care Claim Payment/Advice Form).*

- Do you want to order PC-ACE Pro32 software for use in your office? *(if yes, please fill out a PC-ACE Pro32 software license agreement)*
 Yes No Do you have internet access? Yes No

7. **Method of Electronic Access** *(please check one)*

- IVANS
- FTP
- Dial-up *(If dial-up check desired protocol below)*
 - Zmodem Ymodem Kermit Other _____

8. **ANSI Version**

- 004010x098A1 - Professional V 4010A1 claims

9. **An original signature is required for this document. NAS EDI Support Services does not accept faxed copies of this form. NAS EDI Support Services will only process forms that are mailed in and contain the appropriate original signature.**

I authorize the set-up noted above for the 837 Professional claims transaction.

Signature _____

Date _____