MARYLAND MEDICAL CARE PROGRAMS
SUBMITTER IDENTIFICATION FORM

For Version 005010 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:	FinThrive FKA TransUnion/MedData
b) Submitter Address:	200 North Point Center East, Suite 400, Alpharetta GA 30022
c) Submitter ID(ISA Qualifier and ISA ID):	271491512

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	005010X279A1
	276/277 Claim Status & Response	005010X212
	837 Health Care Claim Institutional / 277CA Claim Acknowledgment	005010X223A2 / 005010X214X
	837 Health Care Claim Professional / 277CA Claim Acknowledgment	005010X222A1 / 005010X214X
	837 Health Care Claim Dental / 277CA Claim Acknowledgment	005010X224A2 / 005010X214X
	820 Premium Payment	005010X218
	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**:**	005010X221A1

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The provider, _____ hereby authorizes

PROVIDER NAME

_____FinThrive FKA TransUnion/MedData_____, hereafter

SUBMITTER AGENT

referred to as ***Submitter Agent***, to transmit HIPAA transactions to Maryland Medical Care Program, and further authorizes Maryland Medical Care Program to transmit to the ***Submitter Agent*** the return computer electronic files of all data processed. 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**

800-390-7459

_____ _____ _____ _____

Telephone Number **Date** **Telephone Number** **Date**

Note: This form requires completion of all requested information and **original signatures** to be processed.

MAIL TO:

SYSTEMS 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: _____