



Trading Partner Agreement (TPA) / Electronic Data Interchange (EDI) Form

This form is used for initial enrollment to access the Colorado Medical Assistance Program Web Portal. If any of the information provided on this form is updated information, your information in the MMIS will not be updated. To update your provider information in the MMIS, you must either update the information through the Web Portal or complete and submit the Provider Enrollment Update Form located in the Forms section of the Department’s website Colorado.gov/hcpf → For Our Providers → Provider Services → Forms → Update Forms section.

Section 1 - Provider Information

Provider Name: _____ Tax ID or SSN: _____

Application Tracking Number(ATN): _____ Provider NPI Number (optional): _____

Attention: Xerox will not activate your account and assign you a Provider ID number, until **after** they have all required documentation (including this form).

Section 2 - Provider Address and Contact Information

Mailing Street Address: _____ Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Primary Contact Information/ Trading Partner Administrator

Contact First Name: _____ Contact Last Name: _____

Business Street Address: _____ Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

Contact Email Address: _____



Secondary Contact Information/ Trading Partner Administrator (optional)

Contact First Name: _____ **Contact Last Name:** _____

Business Street Address: _____ **Address Line 2:** _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone Number: _____ **Fax Number:** _____

Contact Email Address: _____

Section 3 - Provider/ Submitter Electronic Information

Colorado Medical Assistance Program rules (8.040.2) require the electronic submission of claims except in certain circumstances. Providers may also retrieve reports electronically. In order to electronically submit claims, or electronically retrieve reports, applicants must complete these sections.

Please indicate how you plan to submit your electronic transactions

- State’s Provider Web Portal Vendor Software
- Billing Agent Clearinghouse

If you have purchased a software or have an in-house software that you will use to submit your own batch transactions, please enter your software vendor’s 5 digit Submitter ID or 6- digit Trading Partner ID: _____

Section 4 - Transactions Available for Receiving Reports

Colorado Medical Assistance Program providers can receive X12N electronic report. Please select the reports that you want to receive through the State’s Provider Web Portal. Enter only one Trading Partner (TP) ID per report. You may enter a different TP ID for each selected report. (The authorization agreement must be completed for each TP ID that is authorized to retrieve reports)

The following reports will be returned to the submitting TP ID

- X12N 277CA Payer Specific Error Report -X12N 999 Acknowledgement of a sent transaction
- X12N 271 Eligibility Response -X12N 277 Claim Status Response

If the Receiving TP ID field is left blank, it will by default be returned to the submitting provider’s TP ID.

<u>Report</u>	<u>Receiving TP ID</u>	<u>Report</u>	<u>Receiving TP ID</u>
<input type="checkbox"/> X12N 820 (Client Capitation)	_____	<input type="checkbox"/> X12N 835(Claim Payment/ Report)	_____
<input type="checkbox"/> Accept/ Reject Report	_____	<input type="checkbox"/> Provider Claim Report	_____
<input type="checkbox"/> X12N 834 (Benefit Enrollment & Maintenance)	_____	<input type="checkbox"/> Par Letters	_____



Section 5 Authorization Agreement

The Authorization must be completed and signed by the provider who wishes to authorize a billing agent, clearinghouse, or other provider to:

- Maintain and control designated reports (Indicated on Section 4)
- Submit designated transactions
- Retrieve designated transactions

The authorized billing agent, clearinghouse, or provider will not be allowed to access information on a provider’s behalf without the submission of this explicit authorization.

Provider, _____ hereby appoints

Billing Agent/ Clearinghouse/ Provider Name

Trading Partner/ Submitter ID

to act as an authorized agent for the purpose of submitting health care transactions electronically on Provider’s behalf to the Colorado Medical Assistance Program.

Provider/Provider Representative Signature: _____

Provider/Provider Representative Name (please print): _____

Date: _____

Attention: please complete this form and mail it to:
Xerox State Healthcare Attn: Provider Enrollment
P.O. Box 1100
Denver, CO 80201

