



Sender Name: _____
 Address (include suite) _____
 City _____ State _____ ZIP _____
 Contact Name _____ Phone () _____
 Email Address _____ FAX () _____
 Tax Identification Number _____
 Current Rendering Network Provider Identifier (RNPI) _____
National Provider Identifier (NPI) _____

Currently Submitting Claims Electronically: Yes No

Select HIPAA 4010 Addenda Transaction(s) which you are interested in submitting and/or receiving information about:

837P Claim (Professional)
 837I Claim (Institutional)
 837D Claim (Dental)
 835 Payment Advice/Remit
 270/271 Eligibility
 276/277 Claim Status
 278 Referral/Authorization

Vendor A: 270/271 278 837 835 276/277
 Vendor Name _____
 Contact Person _____ Contact Person Phone Number _____
Vendor B: 270/271 278 837 835 276/277
 Vendor Name _____
 Contact Person _____ Contact Person Phone Number _____
 If more than two vendors please use back of form.

Please return this completed form via:

<p>Fax: Attn: EDI FAX#: 330-996-8877</p>	<p>Mail: Attn: EDI SummaCare Inc. P.O. Box 3620 Akron, OH 44309-3620</p>
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If you have any questions please call Provider Support Services at 1-800-996-8401.