



HIPAA Transaction Set Form

PLEASE TYPE or PRINT CLEARLY

(* denotes required field)

PROVIDER INFORMATION

*Provider Name: _____

Indicate the Program for EDI Submission: QUEST Medicare

Federal Tax ID: _____ Are you signed up for AC Online? Yes No

Name of software used for EDI Submission (If not applicable indicate "NA"): _____

PROVIDER CONTACT INFORMATION

*Name: _____ *Phone: (____) _____

Email: _____ Fax: (____) _____

*Preferred Method of Contact: Phone Fax Email

CLEARING HOUSE/THIRD PARTY CONTACT INFORMATION

*Name: _____ *Phone: (____) _____

Email: _____ Fax: (____) _____

*Preferred Method of Contact: Phone Fax Email

LIST USERS for EDI TRANSACTIONS (Note: Users must be registered for AC Online)

1		3	
2		4	

TRANSACTION SET STATUS (please indicate which EDI services you will be testing/using)

Set ID	Transaction Set Description	Ready for Testing (Y/N)	Comments
837P	Professional Claim (HCFA/CMS-1500)		
837I	Institutional Claim (UB92/UB04)		
835	Claim Remittance		
270/271	Eligibility		
276/277	Claim Status		
278	Referral/Authorization		

*REQUIRED INFORMATION for INSTITUTIONAL CLAIMS ONLY

Type of Facility	Fed. ID Number	NPI Number	QUEST Provider ID#	Medicare Provider ID#
Acute				
SNF				
Swing				
Home Health Agency				

Fax completed form to AlohaCare
Attention: Provider Relations Department
Fax: (808) 973-0811