



**MEDICARE  
Electronic Data Interchange**

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**General Completion Instructions For EMC Change Of Information Form**

A signed EDI Enrollment Form must be submitted before a provider may begin to submit/receive EDI transactions for the first time.

**\*\*Attention:** The sender/submitter is required to notify Medicare EDI in writing in advance of any changes impacting their use of EDI and the effective date of such change. Medicare EDI must be notified if the provider will begin, change, or discontinue using a billing service, clearinghouse, or other third party, as well as of any changes related to electronic transactions the provider uses.

**Please review the completion instructions carefully as the type of change requested determines what information is required. If all of the required information is not provided, the form will be returned for the additional information.**

**Section A: Select type of change.**

**Add a provider to an existing Sender/Submitter:** This will add a provider to an existing sender/submitter for electronic claim submission. When requesting to add complete Sections B: 1-9 and C: 1.

**Delete a provider from an existing Sender/Submitter:** This will remove a provider from an existing sender/submitter relationship for electronic claims submission. When requesting to delete a provider from a sender/submitter, complete Sections B: 1-9 and C: 1.

**Delete Sender/Submitter Number:** Indicate the sender/submitter number you wish to delete entirely from our Medicare system. Please complete Section C: 1-7.

**Change of Sender/Submitter Address:** Indicate the updated sender/submitter address information. Complete Section C: 1-7. This form cannot be used to update a provider's address. For information about changing a provider's address, please contact the Provider Contact Center at (866) 454-9007 for FL Part B, or (888) 760-6950 for CT Part B.

**Change of Sender/Submitter Contact Person:** Indicate the contact name you wish to add as the sender/submitter new contact representative. When changing sender/submitter contact person, complete Section C: 1 and 5.

**Email Address:** Indicate sender/submitter new email address. Please complete Section C: 1 and 2. Make sure that the Email information on the line provided is legible.

**Section B: All Fields Are Required Unless Indicated Otherwise**

1. **Provider Name:** Print the name of the billing provider, Supplier/PA group/Clinic/Hospital.
2. **Provider Address:** The physical address where services are performed must be listed.
3. **City/State/Zip:** Indicate the city/state/zip for the provider, Supplier/PA group/Clinic/Hospital.
4. **National Provider Identifier (NPI):** Indicate the billing provider's NPI.

5. **Tax Identification/SS Number:** Indicate the billing provider's tax identification number. If you do not have a tax identification number, indicate the billing provider's Social Security Number.
6. **Medicare Provider Number (if known):** Indicate the billing provider's Medicare provider number (if known).
7. **Name of Person Requesting this Change:** Please print the name of the person requesting the change.
8. **Signature of Provider or Authorized Party for The Provider:** The signature of the provider or authorized party for the provider is required. When the provider is using a third party, e.g., clearinghouse, billing service, to exchange EDI transactions, the signature serves as the provider's authorization for the third party to act on behalf of the provider for the indicated EDI transaction(s). In such cases the provider is required to have on file, an agreement signed by that third party in which the third party has agreed to meet the same Medicare security and privacy requirements that apply to the provider in regard to viewing or use of Medicare beneficiary data. **A representative from a billing service or clearinghouse is not authorized to sign on behalf of the provider.**
9. **Effective Date:** Effective date on which the provider, Supplier/PA group/Clinic/Hospital will begin, change, or discontinue using a billing service, clearinghouse or other third party.

**Section C: All Fields Are Required Unless Indicated As Optional or Conditional**

1. **Sender/Submitter Number:** Indicate the sender/submitter number for which the requested change applies.
2. **Sender/Submitter Name of Company (Conditional):** Indicate the name of the sender/submitter.
3. **Sender/Submitter Address (Conditional):** Indicate the sender/submitter address.
4. **City/State/Zip (Conditional):** Indicate the sender/submitter city, state and zip code.
5. **Contact Person (Conditional):** Indicate the name of the person to contact regarding this application.
6. **Telephone (Conditional) /Fax Number (Optional):** Indicate the sender/submitter telephone/fax number.
7. **Effective Date:** Effective date of the sender/submitter number deletion.

**Section D: Optional.**

**Comments:** Any concerns or consideration you wish to add to sender/submitter file.



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**EMC CHANGE OF INFORMATION FORM**

To avoid any delays in processing, please make sure you complete the information in each section that applies to the specific EMC type of change requested.

**Section A:**

**Type of change:** Select one per request and complete each Section specified.

\_\_\_\_\_ Add a Provider to an existing sender/submitter number. Complete Sections B: 1-9, and C: 1.

**(Provider is required to have a valid EDI Enrollment Form containing a signature on file).**

\_\_\_\_\_ Delete a provider from an existing sender/submitter number. Complete Sections B: 1-9 and C: 1.

\_\_\_\_\_ Delete a sender/submitter number. **This will delete the sender/submitter number entirely.**  
Please complete Section C: 1-7.

\_\_\_\_\_ Change of sender/submitter address. Complete Section C: 1-5.

\_\_\_\_\_ Change of sender/submitter contact person. Complete Section C: 1 and 5.

\_\_\_\_\_ Email Address Change: (Indicate Here) \_\_\_\_\_  
Complete Section C: 1 and 2.

**Section B: All Fields Are Required Unless Indicated Otherwise**

1. **Provider name:** \_\_\_\_\_
2. **Provider address:** \_\_\_\_\_
3. **City/State/Zip:** \_\_\_\_\_
4. **NPI:** \_\_\_\_\_ (National Provider Identifier)
5. **Tax ID/SS Number:** \_\_\_\_\_
6. **Medicare Provider Number:** \_\_\_\_\_ (if known)
7. **Name of person requesting this change:** \_\_\_\_\_
8. **Signature of provider or authorized party for the provider:** \_\_\_\_\_
9. **Effective Date:** \_\_\_\_\_

**Section C: All Fields Are Required Unless Indicated As Optional or Conditional**

1. **Sender/Submitter number:** \_\_\_\_\_
2. **Sender/Submitter name of company** (Conditional): \_\_\_\_\_
3. **Sender/Submitter address** (Conditional): \_\_\_\_\_
4. **City/State/Zip** (Conditional): \_\_\_\_\_
5. **Contact person** (Conditional): \_\_\_\_\_
6. **Telephone No** (Conditional): \_\_\_\_\_ **Fax No** (Optional): \_\_\_\_\_
7. **Effective Date** (Conditional): \_\_\_\_\_

**Section D:** Optional.

**Comments:**

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**NOTE:** If you have any questions concerning this request, please contact Medicare EDI.

Florida: (904) 791-8767, option 2

Connecticut: (203) 639-3160, option 1

Fax or mail completed form to:	MEDICARE EDI	MEDICARE EDI
<b>Fax: (904) 791-6692</b>	Attn: Enrollment Team – 14T	Attn: Enrollment Team – 14T
	P.O. Box 44071	532 Riverside Avenue
	Jacksonville, FL 32231	Jacksonville, FL 32202