51103

EDI Submitter ID Update Request Form

Please complete this form and return it to First Coast Service Options to update the information we have on file to mail you EDI-related documents.

All fields marked with an * are required. Please print clearly.

*Contract/State (required): [ ] * Line of Business: ☐ Part A (Institutional) ☐ Part B (Professional)

Tax ID: ______________________________

* Current Legal Business Name: ______________________________

* Current EDI Trading Partner/Submitter ID: ______________________________

Current Fax Number: ______________________________

All Submitter IDs for the same organization will be updated.

Change information on file to (check only those that apply):

☐ Mailing Address: ______________________________

City: ____________ State: ____________ Zip Code: ____________

☐ Contact Person: ______________________________

☐ Contact Person's Telephone Number: ______________________________

☐ Contact Person's Fax Number: ______________________________

☐ Contact Person's Email Address: ______________________________

Email address may be used for enrollment processing response and will be added to Medicare EDI listservs.

Complete form, sign and date, and return all pages to:
Email: MedicareEDI@fcso.com
Fax: (904) 361-0470
Post: First Coast Medicare EDI
P.O. Box 3703
Mechanicsburg, PA 17055-1861

SIGNATURE:

Providers: The Authorized Official signing this form should be an AUTHORIZED OR DELEGATED OFFICIAL that was listed on the Medicare Enrollment Application (CMS-855).

Signature: ______________________________ Date: ______________________________

Printed Name: ______________________________ Title: ______________________________

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