Hawaii Medicaid Fiscal Agent
ELECTRONIC DATA INTERCHANGE
TRADING PARTNER ENROLLMENT FORM

CONDUENT

A. SUBMITTER/BILLING AGENT INFORMATION

PLEASE INDICATE YOUR CLASSIFICATION:

☐ **Provider** ☐ **Billing Agent**

A1.	Submitter/Billing Agent Name:			
	Address:			
	City, State, Zip:			
	Telephone #:		FAX #:	
	Provider Number:		EIN:	
	Group Provider Number:		EMAIL ADDRESS:	
	Provider Specialty:			

A2.	**Please indicate contact information, if different from Submitter/Provider Information in Section A1:**	
	Contact name:	
	Contact Title:	
	Address	
	City, State, Zip:	
	Telephone #:	
	Fax #:	
	Email Address	

A3. **If you plan to allow your Billing Agent to submit electronically on your behalf, please indicate the following information and sign below:**

BA Name:						Contact name:	
Address:						Phone Number:	
City:		State:		Zip:		Fax Number:	

_____ _____

Signature **Date**

Note: ***Your Billing Agent must be equipped with their own uniquely assigned Conduent EDI Solutions Submitter ID to submit claims on your behalf. Please contact your Billing Agent to confirm their status with Conduent EDI Solutions.***

Please indicate your Billing Agent's 5 digit Submitter ID or 6 digit Trading Partner ID: ☐☐☐☐☐☐

Please return complete forms via Mail or FAX to: **(808) 952-5595**
EDI ENROLLMENT DEPARTMENT 1132 Bishop Street., Suite 800 Honolulu, HI 96813
(Incomplete forms will cause a delay in processing and are subject to return.)

B. SUBMISSION METHOD

B1. Please check the appropriate Submitter, Format and Transaction type(s) below:

	Submitter Type
☐	I am a provider who will submit and retrieve my response via the WINASAP5010 Software.
☐	My Billing Agent will submit to the Hawaii Medicaid Fiscal Agent and retrieve responses on my behalf using WINASAP5010.

	Format and Transaction Type
☐	X12N 837 Professional
☐	X12N 837 Institutional
☐	X12N 837 Dental