835 Request Form

CareOregon

Provider information

Provider billing name: _____

Provider tax ID number: _____

Billing address : _____

City: _____ State: _____ ZIP: _____

NPI: _____ Check #: _____
(any check number previously issued by CareOregon)

Clearinghouse information - CareOregon EDI Payer ID 93975

I authorize CareOregon to work directly with the following clearinghouse for retrieval of our 835 files.

☐ **Yes** ☐ **No**

Name of clearinghouse: _____

Contact name: _____

Emailt address : _____

Phone: _____ Trading partner ID*: _____

**Also referred to as a submitter id used in order to exchange electronic transactions.*

Please note: *it is the provider's responsibility to notify CareOregon if they no longer want us to share files directly with the clearinghouse.*

Contact Information/Authorized Signature (835 recipient)

Last name, first name: _____

Phone: _____

Company title: _____ Fax #: _____

Email addresses:

1. _____
2. _____
3. _____

Authorized signature: _____

Print name: _____ Date: _____

When this form is complete:

Return by secure email to:
SysApps@careoregon.org

Or return by fax to:
503-416-1437

Or return by mail to:
CareOregon
315 SW Fifth Ave
Portland, OR 97204

Retain a copy for your records.