

MIDWEST HEALTH PLAN, Inc.

EDI DIRECT SUBMITTER REQUEST

SUBMITTER DATA

SUBMITTER NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PRIMARY CONTACT: _____

PHONE NUMBER: _____ FAX NUMBER: _____

Email ADDRESS: _____

PROVIDER TAX ID # _____

Type of claims submitting: ___ Professional ___ Facility

Approximate number of claims each month: _____

**(Check one) ___ EDI BILLING SERVICE or ___ CLEARINGHOUSE DATA
___ Direct entry onto Midwest Website (Pre-Log) ___ Upload 837 single TID claims**

** NOTE ALL PROVIDERS FOR WHOM YOU SUBMIT CLAIMS MUST HAVE AN EDI PROVIDER INFORMATION FORM ON FILE WITH MIDWEST HEALTH PLAN. EACH CLAIM MUST BE SUBMITTED WITH Billing/Group NPI in loop 2010 and Rendering provider NPI in loop 2310.

Please Fax completed forms and completed w-9 to the number listed below

FAX: 313-827-9069

www.midwesthealthplan.com

MIDWEST HEALTH PLAN SUBMITTER ID # _____ (assigned by Midwest Health Plan)