

**CEMENT & CONCRETE WELFARE FUND
EDI REGISTRATION**

As a prerequisite for doing electronic transactions with the Cement & concrete Welfare Fund, each potential trading partner must complete and return this registration form. Incomplete forms will NOT be processed. Once completed, please send the form along with the executed Trading Partner Agreement to the Cement & Concrete Welfare Fund. Lastly, be sure to maintain a copy of this form for your records.

TRADING PARTNER INFORMATION

Today's Date:
Name of Provider:
Provider No.:
Street Address:
City, State & Zip Code:
Telephone Number:
Facsimile Number:
EMAIL Address:
Method for Transaction Submission:
Method for Security/Encryption:

Are You Using a Clearinghouse?

Name of Clearinghouse:
Street Address:
City, State & Zip Code
Telephone Number:
Facsimile Number:
EMAIL Address:

Authorized Signer Information

Primary Contact Name:
Title:
Telephone Number:
Facsimile Number:
EMAIL Address:

Secondary Contact Name:
Title:
Telephone Number:
Facsimile Number:
EMAIL Address:

Claims Contact Information

Primary Contact Name:
Title:

Telephone Number:
Facsimile Number:
EMAIL Address:

Secondary Contact Name:
Title:
Telephone Number:
Facsimile Number:
EMAIL address:

EDI SUBMITTER INFORMATION

Name of Submitter:
Street Address:
City, State, & Zip Code:
Telephone Number:
Facsimile Number:
EMAIL Address:

EDI Submitter's Contact Information

Business Contact Name:
Title:
Telephone Number:
Facsimile Number:
EMAIL Address:

Technical Contact Name:
Title:
Telephone Number:
Facsimile Number:
EMAIL Address:

AUTHORIZED TRANSACTIONS

Check all transactions for which authorization should be registered.

- *****EClaims: to process HCFA1500 on-line _____
- _____ 837 Professional Claim Submission
 - _____ 837 Dental Claim Submission
 - _____ 837 Institutional Claim Submission
 - _____ 835 Health Care Claim Payment
 - _____ 820 Group Premium Payment
 - _____ 834 Benefit Enrollment and Maintenance
 - _____ 270 Health Care Eligibility Benefits Inquiry
 - _____ 271 Health Care Eligibility Benefits Response
 - _____ 276 Health Care Claims Status Request
 - _____ 277 Health Care Claims Status Response

_____ 278 Health Care Service Review - Request & Response

Authorized Signature: _____

Name:

Title

Official Use Only

Date Received:

Disposition

___ Processed-Date

___ Returned-Date

___ Hold

Reason/Comments

drafted 9/24/03