51103

Electronic Data Interchange (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 for your EDI submitter ID.

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

General Information

FP167N (R01-22)

*State: Select one from dropdown	*Line of business: Select one from dropdown

Current Provider Information

***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):

☐	Street Address:	City:
	State/Province:	Zip code/Postal 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.

*Required Signatures

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

*Written Signature of Person Submitting Form (add after you print the form)	*Date:
*Printed Name of Person Submitting Form	*Printed Title of Person Submitting Form:

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

Please do not send duplicate forms.

Print Form Clear Form