



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.

Organization information		FP167 (R2-24)
*State:	*Line of business:	

All Submitter IDs for the same organization will be updated.

*Tax ID:	*Current legal business name:
*Current EDI trading partner/submitter ID:	*Current correspondence fax number:
Current correspondence email address:	*Current correspondence telephone number:

Information to be changed (ONLY complete fields that need changed, leave all others blank)	
Updated legal business name:	
Updated correspondence street address:	Updated correspondence city:
Updated correspondence State/Province:	Updated correspondence ZIP code/postal code:
Updated correspondence fax number:	Updated correspondence telephone number:
Updated contact name:	Updated correspondence email address:

Fax number will be used for form processing response.

* Required Signature <small>Providers: The Authorized Official signing this form should be an AUTHORIZED OR DELEGATED OFFICIAL that was listed on the Medicare Enrollment Application (CMS-855).</small>	
*Written Signature of Person Submitting Form: (add after you print the form)	*Date (mm/dd/yyyy):
*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.

