

Employer Group Electronic Termination/Change Form Completion Instructions

The information you provide on this Employer Group Electronic Termination/Change form is used to remove or modify existing electronic submission information. This form should be completed if the employer group no longer wants to submit Health Care Premium Payment (820) or Benefit Enrollment (834) transactions electronically, wants to terminate an old or outdated employer group number, wants to change billing service, clearinghouse, software vendor, or change to direct submission. **Do not** use this form to add additional transactions. To add additional transactions, fill out the appropriate registration form corresponding to that transaction. **Print legibly and complete every section as accurately as possible.**

If a section does not apply, write "N/A".

If you have any additional questions, contact EDI Support Services (EDISS) at (800) 967-7902.



DO NOT utilize this form if you are currently registered with EDISS and have received your 10 digit National Provider Identifier (NPI). Please submit the "NPI Update Request Form" in place of this T/C Form. If you have any questions about which form to complete, please contact EDISS at (800) 967-7902.

CURRENT EMPLOYER GROUP INFORMATION

1. The date indicating when the employer group will be ready to terminate/change the information noted **is required**. **Note:** When processed, the employer group's existing information will be terminated. If the effective date is not indicated, the change indicated on the form will be processed within EDI's standard processing time frame and may impact employer group processing when a change in submission status is involved.
2. The Federal Tax ID of the employer group **is required**. If the Federal Tax ID number is changing, **STOP**. The following steps need to be taken:
 - A change in Federal Tax ID requires a new employer group number. Contact the appropriate enrollment office for assistance.
 - Upon receipt of the new employer group number, use this form to terminate the old number for the applicable electronic transaction. Separate Employer Group Electronic Termination/Change forms must be completed if multiple electronic transactions need to be terminated.
 - Fill out the Exhibit A registration forms corresponding to the electronic transactions that will use the new number. The Exhibit A registration forms are available at www.edissweb.com. Testing with EDISS may be necessary.
3. The current Trading Partner ID and Submitter ID of the employer group.
4. The current employer group number **is required** for any termination/change for these Lines of Business (LOB): Blue Cross, Blue Shield, Dental Services Corporation (DSC), and North Dakota Vision Services, Inc.
5. The current legal business facility name **is required**.
6. Check the corresponding box to indicate the transaction that will be terminated/changed. Select only the transaction type to which this termination/change applies. **Do not** use this form to add transactions. To add additional transactions, fill out the appropriate Exhibit A registration form corresponding to that transaction located at www.edissweb.com.
7. Check the box to indicate which LOB the termination/change applies for the transaction selected in number 6.

EMPLOYER GROUP NUMBER TERMINATION

8. Fill in the employer group number to be terminated for the transaction selected in number 6 and LOB selected in number 7 (refer to number 4 on the instructions page for the LOB that correspond to the employer group number). Separate Employer Group Electronic Termination/Change forms must be completed if multiple numbers need to be terminated.

CHANGE IN FACILITY INFORMATION

9. Fill in all of the blanks with the requested information for the employer group to indicate a change in facility information. If the change in facility information corresponds to a change in Federal Tax ID, **STOP**. The following steps need to be taken:
 - A change in Federal Tax ID requires a new employer group number. Contact the appropriate enrollment office for assistance.
 - Upon receipt of the new employer group number, use this form to terminate the old number for the applicable electronic transaction. Separate Employer Group Electronic Termination/Change forms must be completed if multiple transactions need to be terminated.
 - Fill out the Exhibit A registration forms corresponding to the electronic transactions that will use the new number. The Exhibit A registration forms are available at www.edissweb.com. Testing with EDISS may be necessary.

Employer Group Electronic Termination/Change Form Completion Instructions (continued)

CHANGE IN SUBMISSION METHOD INFORMATION

10. Complete this section only if you are changing the method you use to send claims to EDISS. Changing to a new software vendor, billing service, or clearinghouse are examples of a change in submission method.
- Check only one box.
 - Complete the section with the new vendor name and software product name.
 - Complete the section with the new contact information.

SIGNATURE

11. The signature section needs to be filled out completely and signed by an appropriate employer group representative. **The complete form with a valid signature must be mailed or faxed to EDISS to avoid any interruptions in your ability to exchange data with EDISS.**

Employer Group Electronic Term/Change Form

EMPLOYER GROUP ELECTRONIC TERMINATION/CHANGE FORM	Phone number: (800) 967-7902 Fax number: (877) 269-1472 Contact us via e-mail at: support@edissweb.com Visit our website at: www.edissweb.com
EDI Support Services PO Box 6729 Fargo, ND 58108-6729	

The information you provide on this Employer Group Electronic Termination/Change form is used to remove or modify existing electronic submission information. This form should be completed if the employer group no longer wants to submit Health Care Premium Payment (820) or Benefit Enrollment (834) transactions electronically, wants to terminate an old or outdated employer group number, wants to change billing service, clearinghouse, software vendor, or change to direct submission. **Do not** use this form to add additional transactions. To add additional transactions, fill out the appropriate registration form corresponding to that transaction. **Print legibly and complete every section as accurately as possible.**

If a section does not apply, write "N/A". If you have any questions concerning the correct completion of the form, contact EDI Support Services (EDISS) at (800) 967-7902.

CURRENT EMPLOYER GROUP INFORMATION

1. **Request a date that the termination/change should be made:** _____/_____/_____

Note: When processed, the employer group's existing information will be terminated. If the effective date is not indicated, the change indicated on the form will be processed within EDI's standard processing time frame and may impact employer group processing when a change in submission status is involved.

2. **Federal Tax ID:** _____

3. **Current Trading Partner ID:** _____ **Current Submitter ID:** _____

4. **Current Employer Group #:** _____

5. **Employer Group Name:** _____

6. Select the **Transaction Type** to which this termination/change form applies.

820 - Health Care Premium Payment

834 - Benefit Enrollment and Maintenance

7. Select the **Line(s) of Business** to which this termination/change form applies (*check only one state*).

Blue Cross

ND WY

Blue Shield

ND WY

Iowa Medicaid IA (**Note:** This Line of Business pertains to the 820 transaction only.)

Dental Service Corporation (DSC) ND

North Dakota Vision Services, Inc. ND

Employer Group Electronic Term/Change Form

EMPLOYER GROUP NUMBER TERMINATION

8. Fill in the blank with the employer group number to be terminated.

Employer Group #: _____

CHANGE IN FACILITY INFORMATION

9. Fill in all of the blanks with the requested information for the employer group to indicate a change in facility information.

Previous Facility Information:

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Contact: _____

Telephone: () _____

Fax: () _____

E-Mail: _____

Updated Facility Information:

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Contact: _____

Telephone: () _____

Fax: () _____

E-Mail: _____

CHANGE IN SUBMISSION METHOD INFORMATION

10. Changing to a new (check one): Software Vendor Billing Service Clearinghouse

New Submission Vendor Name: _____

New Software Product Name: _____

New Vendor Contact: _____

Telephone: () _____ Fax: () _____

SIGNATURE

11. An appropriate valid signature (refer to the Form Completion Instructions) is required for this document.

The complete form with a valid signature must be mailed or faxed to EDISS to avoid any interruptions in your ability to exchange data with EDISS.

As a member of this organization, I am authorized to sign this document on behalf of the provider/facility, and I authorize the set-up noted above.

Signature: _____

Print Name: _____

Title: _____

Date: _____/_____/_____