Wyoming Department of Health
Medicaid Pharmacy Provider
EDI Access Enrollment Form

P. 877.205.8083 | E. PBA_wyprovider@changehealthcare.com | F. 307.426.4169 ***Email or fax form to CHC**

The information provided will be utilized to transmit secure data for the Trading Partner to retrieve via the Change Healthcare Electronic Data Interchange (EDI) Website. Remittance files (835) will be available only to the Trading Partner for the locations that are identified in Attachment A in the Change Healthcare enrollment packet.

*You may enroll as many users as you would like to download/view 835s and electronic Remittance Advices (RAs). Each user needs will have a unique user id. If you need to enroll more than two users, please print off multiple copies of this form.

Pharmacy Name: _____

Trading Partner #: WY_____

Pharmacy NPI: _____

☐ Add ☐ Remove ☐ Edit

Contact Name: _____
(Authorized to retrieve HIPAA and PHI under the Trading Partner Agreement)

Contact Phone # : _____ Contact Fax # : _____

Contact Email Address: _____
(All EDI correspondence will be sent to this address)

Additional Contact: (not required)

☐ Add ☐ Remove ☐ Edit

Contact Name: _____
(Authorized to retrieve HIPAA and PHI under the Trading Partner Agreement)

Contact Phone # : _____ Contact Fax # : _____

Contact Email Address: _____
(All EDI correspondence will be sent to this address)

*Each contact will be issued a login account to retrieve the remittance files available to this Trading Partner.

Approved by Pharmacy	Accepted by Change Healthcare
_____	_____
Authorized Signature	Change Healthcare Authorized Signature
_____	_____
Authorized Signer Name	Change Healthcare Authorized Signer Name
Title: _____	Title: _____
Date: _____	Date: _____