



COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

CHIEF INFORMATION OFFICE BUREAU

**ELECTRONIC DATA INTERCHANGE (EDI)
AGREEMENT FORM**

Please select the transactions that you will send and receive via EDI.

Transaction Type

EDI	Transaction and Type
	837P/835 Professional Claim/Remittance Advice
	837I/835 Institutional Claim/Remittance Advice

***Legal Entity Number _____ Legal Entity Name _____**

* Applicable to Short Doyle Medi-Cal Contract Providers

Contractor Information

By execution hereof by duly authorized representatives, acknowledge, agree to and shall be bound by all the conditions of this Agreement.

FFS Provider No Legal Entity No.	
FFS Provider Name Legal Entity Name	
Federal Taxpayer ID/ Or SSN:	
Authorized Person:	
Authorized Signature:	
Address:	

City/State/Zip:	
FFS or Legal Entity Business Contact Name:	
Title:	
Address:	
City/State/Zip:	
Area Code/Phone Number:	
Fax:	
E-mail:	
Technical/EDI Contact Name:	
Title:	
Address:	
City/State/Zip:	
Area Code/Phone Number:	
Fax:	
E-mail:	

Please return to:

Department of Mental Health
 Chief Information Office Bureau
 EDI Certification Unit
 695 S. Vermont Ave. 11th Floor
 Los Angeles, CA 90005