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# How to Complete the Oregon Medicaid Trading Partner Agreement (TPA) for Electronic Health Care Transactions

Instructions for completing the OHA 2080 form

Last updated July 2017

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# Introduction

- Use the OHA 2080 form (*Trading Partner Agreement for Electronic Health Care Transactions*) to:
  - Sign up to exchange electronic data interchange (EDI) transactions with Oregon Medicaid, and
  - Authorize who will exchange these transactions for you.
- You will also need to submit a new OHA 2080 (TPA) anytime you have changes to your trading partner or submitter information.
- This form (last updated 7/17) is available at [www.oregon.gov/OHA/hsd/ohp/pages/edi.aspx](http://www.oregon.gov/OHA/hsd/ohp/pages/edi.aspx).

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# Definitions

- **Authorized signer:** A person responsible for business activities of the Trading Partner and authorized to sign binding agreements.
- **EDI submitter:** An individual or entity authorized to conduct EDI transactions with OHA as a trading partner or agent of the trading partner as defined on Oregon Administrative Rule (OAR) 943-120-0100.
- **Trading partner:** Provider, prepaid health plan (PHP), coordinated care organization (CCO), clinic or allied agency as defined in OAR 943-120-0100.
- **Trading Partner Agreement (TPA):** A binding agreement between OHA and the Trading Partner. The OHA 2080 form (revised 8/16) is OHA's current TPA form.

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# Responsibilities

- The **Trading Partner** is responsible for submitting the original TPA, and for submitting updated TPAs when changes to the EDI submitter or registered transactions are needed.
- The **EDI Submitter** that you identify on your TPA will be authorized and responsible for the following, for all registered transactions on the TPA:
  - Participating in business-to-business testing with OHA
  - Asking OHA for approval to move from testing to production (e.g., submitting actual claims for payment)
  - Password and log-on information to access the transactions
  - Conducting your transactions
- **Both parties** are responsible for reading and following the OARs at [http://arcweb.sos.state.or.us/pages/rules/oars\\_900/oar\\_943/943\\_120.html](http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html).

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# If you have more than one NPI or Oregon Medicaid ID number

- Complete one TPA for each NPI.
- If your NPI is shared by multiple Oregon Medicaid provider numbers:
  - Use one TPA only if all locations need the same transactions and EDI submitter.
  - If any locations need different transactions or EDI submitters, submit a separate TPA for each location.

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# Requirements for the OHA 2080 form

- OHA will reject submissions that do not meet **all** of the following requirements for completing the OHA 2080 form (TPA):
  1. Complete all required fields (marked with an asterisk).
  2. Enter all Trading Partner information consistent with how the Trading Partner is enrolled with OHA.
  3. Do not use white-out.
  4. The Trading Partner's primary authorized signer and the EDI Submitter's business contact must sign the form using *original ink signatures*.
    - Do not use stamped or copied signatures.
    - Sign in a color other than black so that we can tell the signature is not a copy or stamp.
  5. Mail the *original completed form* to OHA. OHA **does not** accept:
    - Forms submitted by email or fax, or
    - Copies sent by mail.

# OHA 2080 (revised 7/17)

## Page 1

### Trading Partner Agreement for Electronic Health Care Transactions

When to complete this form: Trading partners must complete and submit this form to:

- Sign up to exchange transactions with the Oregon Health Authority (OHA).
- Authorize who will exchange these transactions for you.
- Make any changes to trading partner or submitter information on file with OHA.

How to complete this form:

- If you need to exchange transactions for more than one NPI, complete a TPA for each NPI.
- If you need to exchange transactions for multiple Oregon Medicaid ID numbers, you can use one TPA but only if all locations need the same transactions.
- If you need to authorize more than one clearinghouse/submitter, complete a TPA for each one.
- Please type or print clearly. Fill in all required fields designated with an asterisk (\*). Incomplete forms will NOT be processed.
- Please maintain a copy for your records.
- Mail the completed form to: EDI Support Services, 500 Summer St NE, E44, Salem, OR 97301.

Questions? Email [DHS.EDISupport@state.or.us](mailto:DHS.EDISupport@state.or.us).

This TPA (select one):		<input type="checkbox"/> Fully replaces the current TPA on file. This TPA will end all previous provider/submitter combinations registered under your Oregon Medicaid ID. <input type="checkbox"/> Adds information to the current TPA(s).	
<b>Trading partner information – This cannot be a billing service.</b>			
<b>ONE</b>	*Type (select one):	<input type="checkbox"/> Provider <input type="checkbox"/> Clinic <input type="checkbox"/> Coordinated Care or Managed Care Organization	
	*Business name (as enrolled with OHA):	_____	
	*Physical address:	_____	
	*City, state and ZIP:	_____	
	*Phone number/extension:	_____	
<b>Trading partner authorized signer information – The primary signer signs Part 7 of this form.</b>			
<b>TWO</b>	*Primary signer's name:	_____	
	*Phone number/extension:	_____	*Title: _____
	*Email address (direct, not group, email):	_____	
	Secondary signer's name:	_____	
	Phone number/extension:	_____	Title: _____
<b>Claims contact information – This contact must be a person, not a group.</b>			
<b>THREE</b>	*Primary contact's name:	_____	
	*Phone number/extension:	_____	*Email address: _____
	Secondary contact's name:	_____	
	Phone number/extension:	_____	*Email address: _____
<b>EDI submitter information – If your company intends to exchange transactions directly with OHA, enter "Self" as the submitter name, and enter your company's EDI contact information. If your company intends to use a submitter/clearinghouse, complete this section for the submitter/clearinghouse.</b>			
<b>FOUR</b>	*Submitter name:	_____	
	*Address:	_____	
	*City, state and ZIP:	_____	
	Submitter mailbox #:	MB000	

# OHA 2080 Page 1 – Provider IDs



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\*Trading Partner's National Provider Identifier (NPI):

\*List all taxonomy code(s) registered to this NPI:

\*List the Oregon Medicaid ID(s) associated with this NPI:

- **NPI:** Enter your National Provider Identifier (NPI). If you have more than one NPI to register, you need to submit a TPA for each NPI.
- **Taxonomy codes:** List all taxonomy codes registered to this NPI.
- **Oregon Medicaid ID:** This is the 6- to 9-digit number OHA issued to you when you enrolled as an Oregon Medicaid provider. If you have more than one Oregon Medicaid number that uses this NPI, list them here. (Note: this cannot be a billing service.)

# OHA 2080 Page 1 – Part One

This TPA ( <i>select one</i> ):		<input type="checkbox"/>	Fully replaces the current TPA on file. This TPA will end all previous provider/submitter combinations registered under your Oregon Medicaid ID.				
		<input type="checkbox"/>	Adds information to the current TPA(s).				
ONE	<b>Trading partner information –.</b> This cannot be a billing service.						
	*Type ( <i>select one</i> ):	<input type="checkbox"/>	Provider	<input type="checkbox"/>	Clinic	<input type="checkbox"/>	Coordinated Care or Managed Care Organization
	*Business name ( <i>as enrolled with OHA</i> ):	_____					
	*Physical address:	_____					
	*City, state and ZIP:	_____					
*Phone number/extension:	_____						

- Check if this TPA replaces, or adds to, your existing TPA(s).
- This section identifies the Trading Partner (provider or plan’s) associated with the NPI listed at the top of the form. Enter your:
  - Trading partner type.
  - Business name. This should be your name as enrolled with OHA (e.g., clinic name).
  - Physical address.
  - City, state and ZIP+4 code.
  - Phone number and extension.

# OHA 2080 Page 1 – Part Two

TWO	<b>Trading partner authorized signer information – The primary signer signs Part 7 of this form.</b>
	*Primary signer's name: _____
	*Phone number/extension: _____ *Title: _____
	*Email address ( <i>direct, not group, email</i> ): _____
	Secondary signer's name: _____
	Phone number/extension: _____ Title: _____
	Email address ( <i>direct, not group, email</i> ): _____

- This section identifies your authorized signer. This person will sign the completed TPA and any future updates made to the TPA.
  - Complete all fields for the primary signer.
  - The primary signer may designate a secondary signer who can also sign updates. To do this, also complete the secondary signer fields.

# OHA 2080 Page 1 – Part Three

THREE	<b>Claims contact information</b> – This contact must be a person, not a group.	
	*Primary contact's name: _____	
	*Phone number/extension: _____	*Email address: _____
	Secondary contact's name: _____	
	Phone number/extension: _____	*Email address: _____

- Due to HIPAA privacy rules, OHA will only discuss claims information with the people you list as claims contacts in this section.
  - List at least two contacts familiar with claims submissions.
  - If you need to add more than two contacts, add them to the back Page 1 or attach a separate list on your business letterhead.

# OHA 2080 Page 1 – Part Four

FOUR	<b>EDI submitter information</b> – If your company intends to exchange transactions directly with OHA, enter “Self” as the submitter name, and enter your company’s EDI contact information. If your company intends to use a submitter/clearinghouse, complete this section for the submitter/clearinghouse.
	*Submitter name: _____
	*Address: _____
	*City, state and ZIP: _____
	Submitter mailbox # : MB000

- This section identifies who will exchange your EDI transactions with OHA. If you (the provider or plan) will submit these transactions, enter “Self” as the submitter name. Otherwise, list the EDI submitter’s:
  - Company name
  - Address line 1 (e.g., street address or PO Box)
  - City, state and ZIP+4 code
  - Submitter ID (mailbox number assigned by OHA)

# OHA 2080 (revised 7/17)

## Page 2

<b>FIVE</b>	<b>EDI submitter's contact information</b> – The Business Contact signs Part 8 of this form. OHA will email the Technical Contact when transaction testing is needed. Do not enter a billing service contact as the Technical Contact.	
	*Business contact's name: _____	
	*Phone number/extension: _____	
	*Email address ( <i>direct, not group, email</i> ): _____	
	*Technical contact's name: _____	
	*Phone number/extension: _____ <input type="checkbox"/> Third contact on reverse ( <i>if needed</i> )	
	*Email address ( <i>direct, not group, email</i> ): _____	
<b>SIX</b>	<b>Authorized transactions</b> – Check all transactions that OHA should authorize for your EDI submitter.	
	HIPAA 5010A1 transactions for: <input type="checkbox"/> FFS provider or <input type="checkbox"/> CCO/MCO	
	<input type="checkbox"/>	005010X222A1 837P Professional Claim Submission
	<input type="checkbox"/>	005010X224A2 837D Dental Claim Submission
	<input type="checkbox"/>	005010X223A2 837I Institutional Claim Submission
	<input type="checkbox"/>	005010X221A1 835 Electronic Remittance Advice
	<input type="checkbox"/>	005010X279A1 270 and 271: <input type="checkbox"/> Batch <input type="checkbox"/> Real-time Eligibility Benefits Inquiry and Response
	<input type="checkbox"/>	005010X212 276 and 277: <input type="checkbox"/> Batch <input type="checkbox"/> Real-time Claims Status Request and Response
	<input type="checkbox"/>	005010X218 820 Group Premium Payments
	<input type="checkbox"/>	005010X220A1 834 Benefit Enrollment and Maintenance (CCO/MCO only)
<input type="checkbox"/>	NCPDP 1.2/D.0 Request and Response (B1, B2, B3) (CCO/MCO only)	
<input type="checkbox"/>	Pharmacy Rx Carve-Out File (CCO/MCO only)	
<input type="checkbox"/>	Status file CCO Status File (CCO/MCO only)	
<b>SEVEN</b>	<b>Trading Partner signature</b> – By signing below, the Trading Partner certifies the following:	
	<ul style="list-style-type: none"> <li>I have read the Electronic Data Transmission Oregon Administrative Rules (Chapter 943, Division 120) at <a href="http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html">http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html</a>, and understand my responsibilities as stated in these rules.</li> <li>I authorize OHA to transmit to the <i>EDI Submitter</i> listed in Part 4 of this form the return computer file electronic vouchers of all transactions I have marked in Part 6 of this form.</li> </ul>	
	*Provider, clinic, CCO or MCO name ( <i>from Part 1 of this form</i> ):	*Email address: _____
	*Authorized trading partner signature: _____	*Phone number/extension: _____
	_____	*Date: _____
	<i>Original signature only, of the Primary Signer listed in Part 2</i>	
<b>EIGHT</b>	<b>EDI Submitter signature</b> – By signing below, the EDI Submitter certifies the following:	
	<ul style="list-style-type: none"> <li>I have read the Electronic Data Transmission Oregon Administrative Rules (Chapter 943, Division 120) at <a href="http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html">http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html</a>, and understand my responsibilities as stated in these rules.</li> <li>I agree to protect the confidentiality of the data as required by law.</li> </ul>	
	*Business contact name ( <i>from Part 5 of this form</i> ):	*Email address: _____
	*Authorized EDI submitter signature: _____	*Phone number/extension: _____
	_____	*Date: _____
	<i>Original signature only, of the Business Contact listed in Part 5</i>	

# OHA 2080 Page 2 – Part Five

FIVE	<b>EDI submitter's contact information</b> – The Business Contact signs Part 8 of this form. OHA will email the Technical Contact when transaction testing is needed. Do not enter a billing service contact as the Technical Contact.
	*Business contact's name: _____
	*Phone number/extension: _____
	*Email address ( <i>direct, not group, email</i> ): _____
	*Technical contact's name: _____
*Phone number/extension: _____ <input type="checkbox"/> Third contact on reverse ( <i>if needed</i> )	
*Email address ( <i>direct, not group, email</i> ): _____	

- Enter the EDI submitter's contact information.
  - The Business Contact signs part 8 of this form.
  - The Technical Contact is the person OHA will email when transaction testing is needed.
  - Please list individual emails (not group emails or mailboxes).
  - If you need to add more than two contacts, add them to the back Page 2 or attach a separate list.

# OHA 2080 Page 2 – Part Six

Authorized transactions – Check all transactions that OHA should authorize for your EDI submitter.		
<b>SIX</b>	HIPAA 5010A1 transactions for: <input type="checkbox"/> FFS provider or <input type="checkbox"/> CCO/MCO	
	<input type="checkbox"/> 005010X222A1 837P	Professional Claim Submission
	<input type="checkbox"/> 005010X224A2 837D	Dental Claim Submission
	<input type="checkbox"/> 005010X223A2 837I	Institutional Claim Submission
	<input type="checkbox"/> 005010X221A1 835	Electronic Remittance Advice
	<input type="checkbox"/> 005010X279A1 270 and 271: <input type="checkbox"/> Batch <input type="checkbox"/> Real-time	Eligibility Benefits Inquiry and Response
	<input type="checkbox"/> 005010X212 276 and 277: <input type="checkbox"/> Batch <input type="checkbox"/> Real-time	Claims Status Request and Response
	<input type="checkbox"/> 005010X218 820	Group Premium Payments
	<input type="checkbox"/> 005010X220A1 834	Benefit Enrollment and Maintenance (CCO/MCO only)
	<input type="checkbox"/> NCPDP 1.2/D.0	Request and Response (B1, B2, B3) (CCO/MCO only)
	<input type="checkbox"/> Pharmacy	Rx Carve-Out File (CCO/MCO only)
	<input type="checkbox"/> Status file	CCO Status File (CCO/MCO only)

- Mark the transactions you want to exchange with OHA that are appropriate for your line of business. For example:
  - If you are not a CCO or MCO, do not mark any listed as “CCO/MCO only.”
  - If you are a dentist and want to bill OHA, mark the 837D (Dental Claim Submission).

# OHA 2080 Page 2 – Part Seven

<b>SEVEN</b>	<b>Trading Partner signature – By signing below, the Trading Partner certifies the following:</b>	
	<ul style="list-style-type: none"><li>I have read the Electronic Data Transmission Oregon Administrative Rules (Chapter 943, Division 120) at <a href="http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html">http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html</a>, and understand my responsibilities as stated in these rules.</li><li>I authorize OHA to transmit to the <i>EDI Submitter</i> listed in Part 4 of this form the return computer file electronic vouchers of all transactions I have marked in Part 6 of this form.</li></ul>	
	*Provider, clinic, CCO or MCO name ( <i>from Part 1 of this form</i> ):	*Email address:
	*Authorized trading partner signature:	*Phone number/extension:
		*Date:
<i>Original signature only, of the Primary Signer listed in Part 2</i>		

- The Primary Signer (listed in Part Two) completes this section.
  - Sign the form using ink in a color other than black.
  - The name must match the business name listed in Part One.
  - The email address and phone number must match that of the Primary Signer listed in Part Two.

# OHA 2080 Page 2 – Part Eight

<b>EIGHT</b>	<b>EDI Submitter signature – By signing below, the EDI Submitter certifies the following:</b>	
	<ul style="list-style-type: none"><li>I have read the Electronic Data Transmission Oregon Administrative Rules (Chapter 943, Division 120) at <a href="http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html">http://arcweb.sos.state.or.us/pages/rules/oars_900/oar_943/943_120.html</a>, and understand my responsibilities as stated in these rules.</li><li>I agree to protect the confidentiality of the data as required by law.</li></ul>	
	*Business contact name ( <i>from Part 5 of this form</i> ):	*Email address:
	*Authorized EDI submitter signature:	*Phone number/extension:
		*Date:
	<i>Original signature only, of the Business Contact listed in Part 5</i>	

- The EDI Submitter business contact (listed in Part Five) completes this section.
  - Sign the form using ink in a color other than black.
  - The name, title, email address and phone number must match that of the Business Contact listed in Part Five.

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# Contact information

- **Mailing instructions:** Send your signed, original OHA 2080 form to:  
  
EDI Support Services  
OHA Health Systems Division  
500 Summer St NE, E44  
Salem, OR 97301
- **Need help?** If you have questions about completing this form, please email EDI Support Services at [dhs.edisupport@state.or.us](mailto:dhs.edisupport@state.or.us).