

How to complete the 835 Signup Form

About the 835 Signup

The 835 Signup on the Provider Web Portal at <https://www.or-medicaid.gov> allows providers to request the 835 Electronic Remittance Advice (ERA).

Who can use the 835 Signup

The 835 Signup is only for providers who have a current Oregon MMIS Trading Partner Agreement (TPA) with the Oregon Health Authority. To learn more about becoming a registered Oregon MMIS Trading Partner, [visit the main Electronic Data Interchange page](#).

Trading Partners – When to submit a new TPA

Registered Trading Partners who use the 835 Signup must also submit a new TPA ([OHA 2080](#)) if any of the following applies:

- If you exchange EDI transactions through a clearinghouse and are adding the 835 as a “New Enrollment” using this form. On the new TPA, show that you are adding the 835 as a registered transaction.
- If any identifying information (e.g., TIN, NPI, and Oregon Medicaid Provider ID) does not match your current TPA. On the new TPA, update all appropriate information.

835 Signup – Line-by-line instructions

All fields marked with an asterisk are required. When all fields are completed, click “Save” to submit your request.

Provider Information

Please fill out completely. All fields in this section are required.

Provider Name*	Enter the complete legal name of institution, corporate entity, practice or individual provider.
Provider Address*	Enter the provider address: <ul style="list-style-type: none">■ Street: The number and street name.■ City: City associated with provider address field■ State: Two character state value■ Zip Code/Postal Code: ZIP code

Provider Identifier Information

Provider Tax ID Type/ Tax ID*	<ul style="list-style-type: none">■ Select the Tax ID type: Employer Identification Number (EIN) or Social Security Number (SSN).■ Enter the 9-digit Tax ID (EIN or SSN).
NPI*	Enter the 10-digit National Provider Identifier (NPI) associated with your Oregon Medicaid Provider ID.
Assigning Authority Provider Number*	Enter your 6- or 9-digit Oregon Medicaid Provider ID number.

Trading Partner ID	Enter your 8-digit Oregon Medicaid Submitter ID. This number begins with the letters “MB,” followed by a series of six numbers.
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Provider Contact Information

Provider Contact Name*	Enter name of the person in your office who normally handles EFT/ERA issues.
Telephone Number*	Enter the telephone number of this contact person.
Email Address	Enter the email address of this contact person.
Fax Number	Enter the fax number for this contact person.

Preference for Aggregation Data

Indicate your preference for group (bulking) claim payments (e.g., account number linkage to provider identifier). This must match your preference for group EFT payments. If you have any questions about aggregation, please email DHS.EDISupport@state.or.us.

Aggregation Tax ID Type/ Tax ID	Select how you prefer to group claim payment information: <ul style="list-style-type: none"> ■ By Provider Tax Identification Number (TIN), or ■ By National Provider Identification (NPI)
Method of Retrieval	Choose how you will receive the ERA (835) from OHA: <ul style="list-style-type: none"> ■ By HTTPS, or ■ By SFTP.

Electronic Remittance Advice Clearinghouse Information (if applicable)

If you exchange EDI transactions through a clearinghouse, please complete this section.

Clearinghouse Name	Enter the official name of the provider’s clearinghouse.
Telephone Number	Enter the telephone number your clearinghouse contact
Email Address	Enter the email address of your clearinghouse contact.
Reason for Submission	Explain why you are submitting an 835 signup request by selecting one of the following: <ul style="list-style-type: none"> ■ New Enrollment (if you are not currently signed up for the 835 transaction though your clearinghouse). ■ Change Enrollment (if you are currently signed up for the 835 transaction through your clearinghouse)

Authorized Signature

Electronic Signature of Person Submitting Enrollment*	Enter the full name of the individual authorized to initiate, modify or terminate an enrollment.
Printed Title of Person Submitting Enrollment*	Enter the title of the authorized individual.
Submission Date*	The date on which the enrollment is submitted. This field automatically populates with the current date.
Requested ERA Effective Date*	Enter the date you want to start receiving the ERA 835. If, after this start date, you do not receive the ERA 835 files within 4 business days of receiving the corresponding EFT file, email DHS.EDISupport@state.or.us .