

## HIPAA TESTING REQUEST

Date: \_\_\_\_\_

Mailbox ID (Logon ID #): EDI \_\_\_\_\_ or HAR \_\_\_\_\_

Submitter/Provider Name: \_\_\_\_\_

Provider Number: \_\_\_\_\_

Submitter/Provider Address: \_\_\_\_\_

Submitter/Provider City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Contact Person: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Name of your software vendor or clearinghouse: \_\_\_\_\_

Name of the billing software: \_\_\_\_\_

Number of claims submitted: \_\_\_\_\_

Submitter number (ISA06) \_\_\_\_\_

Component Element Separator (the default is ":") \_\_\_\_\_

Data Element Separator (ISA01, the default is "\*") \_\_\_\_\_

Segment Terminator (the default is "~") \_\_\_\_\_

Interchange ID (ISA06) \_\_\_\_\_

Are your files:  wrapped  unwrapped

**\*In order to set up a new mailbox, please allow 10-14 business days for processing\***

**Due to HIPAA Privacy, please use invalid HIC#s when test claims are being submitted. \*This is for software vendors only.\***

This request may be sent to:

Mutual of Omaha-Medicare  
Attn: LL2 - Medicare Business Systems Analyst  
Mutual of Omaha Plaza  
Omaha, NE 68175

Or faxed to 402-351-6188, attention Medicare Business System Analyst.