Medical Provider Electronic Data Interchange (EDI) Forms

Dear Medical Provider:

LogistiCare offers a secured web portal designed to allow medical facilities to request trips and standing orders from LogistiCare electronically. LogistiCare will provide two (or more upon request) administrative logins to the web portal for each medical facility. The medical facility administrators are required to manage access to the web portal for all other users at their facility.

To use the portal, you must register with our Facilities department. The attached user forms must be filled out, signed and faxed to the LogistiCare Facility department you normally work with to request transportation services.

The LogistiCare Facility department will call or fax the user login information to the user. Once your administrative users are setup, those users can create additional logins for other employees at your facility as needed.

Medical Facility
EDI Administrator User Form

Please Type or Print Clearly

Date: _____

Facility Name: _____

Mailing Address: _____

_____

Phone Number: _____ Fax Number: _____

Medicaid Provider Number or NPI Number: _____

Access: Select one option:

- ☐ Add New Administrative User
- ☐ Inactivate Administrative User
- ☐ Password Reset

User Name: _____

User Email Address: _____

User Job Title: _____

By signing this form, I hereby agree that:

- I will abide by all federal and state regulations pertaining to protected health information (PHI) including the Health Insurance Portability and Accountability Act ("HIPAA").
- I will only provide portal access to employees at my medical facility that have a need to request or review transportation requests.
- I will remove terminated users or users who no longer need access to the portal immediately.
- LogistiCare may remove portal access for me or my medical facility at any time, with or without cause.
- I will use the system in accordance with LogistiCare's documented instructions.
- I will not share my user ID or password with another user.
- I understand that the intentional entry of invalid or false information is unlawful and may have significant adverse legal repercussions.
- I will notify LogistiCare immediately if I believe a security incident has occurred.

User Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Witness Name: _____ Title: _____

(Witness must work at the same medical facility)

TO BE COMPLETED BY LOGISTICARE FACILITY DEPARTMENT:

User ID Assigned: _____

Employee Completing Request: _____

Date Completed: _____