Trading Partner Application and Enrollment Form

To be completed by entities requesting to receive Texas Medicaid information from the Texas Health and Human Services Commission (HHSC) via a HIPAA-compliant transaction.

Contact Information	
Legal Name (Last, First, M.I.):	
Legal Address (Street, City, State, ZIP):	
DBA (Doing Business As) Name:	Contact Name:
Email Address:	Telephone:
State in which your company is incorporated:	

Entity Type (*check all that apply*)

☐ Provider Using Your Own Proprietary Software	☐ Software Developer (does not submit claims)
☐ Billing Agent, Business Agent, or Third-Party Billing Vendor	☐ Healthcare Clearinghouse
☐ Switch or Switching Company, as defined in *State Medicaid Manual*, Chapter 2, § 2080.18	

Type of Access Requested

☐ **Acute Care**	☐ **Long Term Care**	☐ **CHIP**

Attestation

Entities that provide services for Texas State Health-Care providers must have a business agreement with those providers. Please provide a copy of the business agreement that you use with your providers.

☐ I attest that I have signed business agreements with all of the providers for whom I provide services.

Note: *You must provide copies of the business agreements to HHSC if requested.*

Subcontractor Information

Will you be using a subcontractor to access the system for you? ☐ Yes ☐ No ☐ Not Applicable
If "Yes," provide the following information:

Subcontractor's Legal Name (Last, First, M.I.):	
Subcontractor's Legal Address (Street, City, State, ZIP):	
DBA (Doing Business As) Name:	Contact Name:
Email Address:	Telephone:
Is the subcontractor an existing trading partner? ☐ Yes ☐ No	If Yes, enter Submitter ID:

Data Collection, Use, and Retention

Is data retained? ☐ Yes ☐ No If "Yes," please list how long the data will be retained, and for what purpose:

Access to Information

Will data be accessed by other entities or persons? ☐ Yes ☐ No If "Yes," please provide the legal name and address for such entities and for what purpose the information is being accessed: