**FLORIDA DEPARTMENT OF FINANCIAL SERVICES**

**DIVISION OF WORKERS’ COMPENSATION**

**Medical EDI - Revision F**

**Sender Contact Update**

**Sender Name:**        **ID #:**

***Additional Contact Person(s):*** Provide the following information for all persons to whom EDI test and production communications should be sent (i.e., Transmission Receipt Confirmations and Medical Bill Acknowledgement Reports).

**Contact Name (1):**

**Job Title:**

**Email:**

**Address:**

**Contact Type:** Business  Technical  Both

**Please select notification preferences:**

File Receipt Acknowledgement

Global Emails

Medical Bill Acknowledgement Reports

Monthly Report Cards

Outstanding Rejected Medical Bill Report

**Contact Name (2):**

**Job Title:**

**Email:**

**Address:**

**Contact Type:** Business  Technical  Both

**Please select notification preferences:**

File Receipt Acknowledgement

Global Emails

Medical Bill Acknowledgement Reports

Monthly Report Cards

Outstanding Rejected Medical Bill Report

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES**

**DIVISION OF WORKERS’ COMPENSATION**

**Medical EDI - Revision F**

**Sender Contact Update**

**Continued from Page 1**

**Contact Name (3):**

**Job Title:**

**Email:**

**Address:**

**Contact Type:** Business  Technical  Both

**Please select notification preferences**

File Receipt Acknowledgement

Global Emails

Medical Bill Acknowledgement Reports

Monthly Report Cards

Outstanding Rejected Medical Bill Report

**Contact Name (4):**

**Job Title:**

**Email:**

**Address:**

**Contact Type:** Business  Technical  Both

**Please select notification preferences**

File Receipt Acknowledgement

Global Emails

Medical Bill Acknowledgement Reports

Monthly Report Cards

Outstanding Rejected Medical Bill Report

***Delete the Following Contact(s):*** Provide the name of the contact to be removed from any future test or production communication.

**Contact Name:**      **Contact Name:**     

**Contact Name:**      **Contact Name:**     