State of California
Department of Industrial Relations

DIVISION OF WORKERS' COMPENSATION

MEDICAL

ELECTRONIC DATA INTERCHANGE TRADING PARTNER PROFILE

PART A. Trading Partner Background Information:

Date:

Sender Name:_____

Sender Master FEIN: _____

Physical Address: _____

City: _____ State: _____

Postal Code: _____

Mailing Address: _____

City: _____ State: _____

Postal Code: _____

Trading partner type (check all that apply):
__ Self Administered Insurer
__ Self Administered, Self-Insured (employer) __ Other (Please specify):____
__ Third Party Administrator of Insurer
__ Third Party Administrator of Self-Insured (employer)

PART B. Trading Partner Contact Information:

Business Contact:	Technical Contact:
Name: _____	Name: _____
Title: _____	Title: _____
Phone: _____	Phone: _____
FAX: _____	FAX: _____
E-mail Address: _____	E-mail Address: _____

PART C. Trading Partner Transmission Specifications:

Part C1 - Please complete the following:
If submitting more than one profile, please specify:

PROFILE NUMBER (1, 2, etc.): _____
DESCRIPTION: _____

Transaction Type	File Format	Expected Days of Transmission (circle any that apply)	Production Response Period
Medical Bill Payment Records	ANSI 837	Daily Monday Tuesday Wednesday Thursday Friday Saturday Sunday Weekly	

Part C2 - FTP ACCOUNT INFORMATION FOR MEDICAL BILL

	DWC Use Only
User Name: (A-Z, a-z, 0-9) _____ **For PGP user only:** suffix of @***wcismed_pgp*** will be required after your user name.	
Password: (8 characters min.) _____	
Transmission Modes: (choose one) _____ **PGP+SSL** _____ **SSL**	
Source Public Network IP Address: (limit to 6 max.) _____	
File Naming Convention: **Prefix:** (max. 4 characters) _____ **Unique Identifier:** (choose one) ___ **Sequence** ___ **Date/Time** ___ **Date/Sequence** ___ **Other** _____	

PART D. Receiver Information (to be completed by DWC):

Name: *California Division of Workers' Compensation*

FEIN: *943160882*

Physical Address: *1515 Clay Street, Suite 1800*

City: *Oakland* State: CA Postal Code: *94612-1489*

Mailing Address: *P.O. Box 420603*

City: *San Francisco* State: *CA* Postal Code: *94142-0603*

Business Contact:	Technical Contact:
Name: *(Varies by trading partner)*	Name: *(Varies by trading partner)*
Title: *(Varies by trading partner)*	Title: *(Varies by trading partner)*
Phone: *(Varies by trading partner)*	Phone: *(Varies by trading partner)*
FAX: 510-286-6862	FAX: 510-286-6862
E-mail Address: *wcis@dir.ca.gov*	E-mail Address: *wcis@dir.ca.gov*

RECEIVER'S ANSI X12 TRANSMISSION SPECIFICATIONS:

Segment Terminator: ~	ISA Information: TEST PROD
Data Elements Separator: *	Sender/Receiver Qualifier: *ZZ ZZ*
Sub-Element Separator: :	Sender/Receiver ID: *(Use Master FEINs)*

Date/Time Transmission Sent (DN100 & DN101):(Format: CCYYMMDDHHMM)