

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

EDI TRADING PARTNER PROFILE

IMPORTANT: Complete all fields designated with an asterisk (*). Form will be returned if any required fields are missing.
Return this page to: _____ Date _____

Receiver Name: Florida Department of Financial Services, Division of Workers' Compensation _____
E-mail: poc.edi@fldfs.com or claims.edi@fldfs.com _____

TRADING PARTNER TYPE* (check all that apply):

Insurer Self-Insurer Service Co/Third Party Administrator Vendor (POC Only)

MASTER TRADING PARTNER INFORMATION:

Sender Legal Name* (no abbreviations): _____

Sender ID: The Federal Employer Identification Number of your business entity. This, along with your 9-digit Postal Code (Zip+4), will be used to identify a unique trading partner. The Sender FEIN and Postal Code provided below should be the same FEIN and Postal Code that will be sent for the **SENDER ID in the Header Record** for your POC and Claims EDI transmissions.

Sender FEIN*: _____ Postal Code* (9 digits): { _____ } – { _____ }

Physical Address/Office Location:

Address Line 1*: _____
Address Line 2: _____
City*: _____ State*: { _____ } Postal Code*: { _____ } – { _____ }

Mailing Address/Office Location:

Address Line 1*: _____
Address Line 2: _____
City*: _____ State*: { _____ } Postal Code*: { _____ } – { _____ }

Contact Information:

- First Report of Injury (FROI) Subsequent Report of Injury (SROI)
 Proof of Coverage (POC)

Business Contact*:
Name: _____
Title: _____
Phone: _____
FAX: _____
E-mail: _____

Technical Contact*:
Name: _____
Title: _____
Phone: _____
FAX: _____
E-mail: _____

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

Preparer Information*:
Name: _____
Title: _____
Phone: _____
FAX: _____
E-mail: _____

Is the Master Trading Partner Address/Office Location provided above also an active claims office location at which workers' compensation claims will be handled/adjusted? _____ * If yes, provide the Claims Manager and Penalty Contact information on Page 2 of this form.

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Claims Manager:

Name: _____
Title: _____
Phone: _____
FAX: _____
E-mail: _____

Penalty Contact:

Name: _____
Title: _____
Phone: _____
FAX: _____
E-mail: _____

Note: The penalty contact should be the associate to whom the Division should direct electronic penalty correspondence as a result of non-compliance with filing and/or payment requirements set out in Chapter 440, F.S., and Administrative Rules 69L-3, 69L-6, 69L-24, and 69L-56, F.A.C.

INDIVIDUAL TRADING PARTNER OFFICE INFORMATION:

Will addresses/office locations other than, or in addition to, the master trading partner address/office location be transmitting EDI filings? _____*

If yes, complete the below address and contact information for each address/office location that will be sending EDI transactions to the Division. Include one sheet for each office location.

Physical Address/Office Location:

Address Line 1: _____
Address Line 2: _____
City: _____ State: { } Postal Code: { } - { }

Mailing Address/Office Location:

Address Line 1: _____
Address Line 2: _____
City: _____ State: { } Postal Code: { } - { }

EDI Business Contact:

Name: _____
Title: _____
Phone: _____
FAX: _____
E-mail: _____

EDI Business Contact:

Name: _____
Title: _____
Phone: _____
FAX: _____
E-mail: _____

EDI Technical Contact:

Name: _____
Title: _____
Phone: _____
FAX: _____
E-mail: _____

EDI Technical Contact:

Name: _____
Title: _____
Phone: _____
FAX: _____
E-mail: _____

Claims Manager:

Name: _____
Title: _____
Phone: _____
FAX: _____
E-mail: _____

Penalty Contact:

Name: _____
Title: _____
Phone: _____
FAX: _____
E-mail: _____