



TRADING PARTNER PROFILE

Trading Partner Name _____ Tax ID _____

Address _____

City _____ State _____ Zip _____

Business Contact Name _____

Phone No. _____ Email Address _____

Copy to email address (optional): _____

Technical Contact Name _____

Phone No. _____ Email Address _____

Copy to email address (optional): _____

Please place an 'X' next to the transactions you want to submit or receive:

837D _____ 999 _____ 835 _____

Trading Partner Type, (e.g. Dentist office, billing service, clearinghouse, other): _____

Will you be using a Clearinghouse? Yes _____ No _____ Name: _____

Trading Partner Authorized Signature _____

Printed Name of Signer _____

Date _____

Telephone No. _____

Email Address _____

For assistance or questions regarding this form please contact our EDI Team at EDITeam@greatdentalplans.com and a representative will contact you. You may return this form via email at EDITeam@greatdentalplans.com.