Provider Electronic Data Interchange
Request Form

Please fill out all fields and email completed form to Sutter Health Plan at **shpedi.support@sutterhealth.org**.

Section A – Partner Information

Partner Name

Partner Alternate Name (If applicable)

Email

Phone

Request Date

Partner IP Address

Please provide information for at least one option below

Interchange 270 Sender ID

Interchange 270 Sender ID

Interchange 835 Receiver ID

Section B – Change (at least one option below)

Transaction Type	Real-time (Yes/No)	Batch (Yes/No)	Test (ADD/NA)	Production (ADD/NA)
270/271				
276/277				
835				

Section C – Contact Info

Request Submitted By

Email

Phone

Approved By (Sutter Health Plan internal use only)

Name

Role

Email

Phone

Sutter Health Plan