

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION**

EDI TRADING PARTNER INSURER/CLAIM ADMINISTRATOR ID LIST

IMPORTANT: Complete all fields designated with an asterisk (*). Form will be returned if any required fields are missing.

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

FROM: Trading Partner*: _____

Sender Legal Name, if different* (no abbreviations): _____

Sender FEIN*: _____ **Postal Code* (9 digits):** _____ - _____

Date Prepared: _____

NOTE: The **Sender FEIN** and **Postal Code** should be the same as those that your company will use as the **SENDER ID in the Header Record** for POC and Claims EDI transmissions, and should match information submitted on your "EDI Trading Partner Profile" (DFS-F5-DWC-EDI-1).

In the first column of the table below, provide the **full Legal Name for all Insurers/Claim Administrators** for which EDI filings will be sent, including self-insurers and any Service Company/Third Party Administrator. In the second column, provide each **Insurer/Claim Administrator FEIN**. In the third column, provide the Division-assigned **Carrier Code # and, if applicable, the Service Co/TPA Code #** for each Insurer/Claim Administrator.

This list will be used to reconcile profile identification records. If after filing this form with the Division, any entries are added or removed from the listing, the trading partner shall submit a revised EDI Trading Partner Insurer/Claim Administrator ID List in accordance with Rule 69L-56, F.A.C.

#	Insurer/Claim Administrator Legal Name* for all Active Claims Offices*	Insurer/Claim Administrator FEIN*	Carrier Code #* Service Co/TPA Code # (if applicable)*
1			
2			
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Use additional page(s) to report more than 20 insurers/claim administrators.