Trading Partner Registration Worksheet

This worksheet can be used to gather the information you will need in order to complete the TPR system registration process. This information may come from several different sources within your organization.

Facility Information

Entity Information

Entity Name*:

Entity Type*:

Street Address*:

City*:

State*:

Zip Code*:

Entity Specialty:

Point of Contact Name*:

Point of Contact Title*:

Point of Contact Phone*:

Point of Contact E-mail Address*:

*Identifier Type (must select at least 1)**

ISO/OID (International Organization for Standardization):

CLIA (Clinical Laboratory Improvement Amendments): ***Required for ELR interface.***

Provider NPI (National Provider Identifier): ***Required for Cancer Registry interface.***

Group NPI (National Provider Identifier): ***Required for Immunization Registry, Syndromic Surveillance, Drug Overdose Reporting interfaces.***

Provider License Number:

Local:

Other Identifier(s):

*Required field: must be completed to move forward in the system.
[+]Contact vendor or IT staff for assistance with this section if needed.
For additional questions, contact MU.Health@tn.gov.

Interface Selection+

Gather information for selected interface(s); if registering for multiple interfaces, gather this information for each interface.

Interface (e.g., Immunization Registry, ELR, Cancer Case Reporting, and Syndromic Surveillance)*:

Point of Contact Name*:

Point of Contact Title*:

Point of Contact Phone*:

Point of Contact E-mail Address*:

HIE and/or HISP Affiliation (if applicable):

File Information+

File Structure Capability (select all that apply)*:	HL7 V2.3.1 Message HL7 V2.5.1 Message HL7 V2.7.1 Message HL7 V2 Other Message HL7 V3 ***Required for Cancer Registry interface*** Other:
HL7 V3 Type (if applicable, select all that apply):	Messages Documents (CDA)
Vocabulary Capability (select all that apply):	LOINC SNOMED UCUM ICD9 ICD10 CPT CVX Adverse Events HL7 Vocabulary NAACCR Version X Other:
File Transport Capability (select all that apply):	SFTP DIRECT SOAP/Web Services PHIN MS Other:

*Required field: must be completed to move forward in the system.
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Intended Mode: Real Time
Batch

Bidirectional: Yes
No
Maybe/Unsure

Current Submission Method:

Application Information[+]

System Type: LIMS or LIS
EHR
Other:

Application Name*:

Application Version:

Application Identifier:

Application ONC Certification Year:

Application ONC Certification ID:

Vendor Point of Contact[+]

Vendor Name*:
Point of Contact Name*:
Point of Contact Title:
Point of Contact Phone:
Point of Contact Email Address:

*Required field: must be completed to move forward in the system.
[+]Contact vendor or IT staff for assistance with this section if needed.
For additional questions, contact MU.Health@tn.gov.

Meaningful Use

This section is required for Meaningful Use participants.

Meaningful Use Entity Type*:	Eligible Hospital Eligible Professional Critical Access Hospital
Stage*:	1 2 3
Year*:	1 2 3
Reporting Period*:	Start Date – End Date

Meaningful Use Point of Contact Name*:

Meaningful Use Point of Contact Title*:

Meaningful Use Point of Contact Phone*:

Meaningful Use Point of Contact Email Address*:

Incentive Program Enrolled (select all that apply): Medicare
Medicaid

*Required field: must be completed to move forward in the system.
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