Department of Consumer and Business Services

Oregon Workers' Compensation Division
Proof of Coverage EDI Transmission Profile

Sender type (check all that apply)

☐ Insurer ☐ Third-party vendor

Sender information

Legal name (no abbreviations): _____
FEIN: _____
IP address: _____
Postal code: _____
Physical address: _____
City, state, ZIP+4: _____
Mailing address: _____
City, state, ZIP+4: _____

Contact information

Name: _____
Title: _____
Phone: _____
Fax: _____
Email: _____

Transaction set information

Transmission Type IAIABC	Format	Release
POC	Flat File	2.1

	Frequency	
☐	Daily	
☐	Other	Describe:

Selected Media
Proof of Coverage: Secure File Transfer Protocol (SFTP) compatible with Open Secure Shell (SSH), Version 2 Protocol

If you have questions about this form, contact the EDI coordinator, 503-947-7742, or email edinews.wcd@dcbs.oregon.gov.

Send to: EDI Coordinator, Workers' Compensation Division, Operations Section, 350 Winter St. NE, P.O. Box 14480, Salem, OR 97309
Or fax to 503-947-7514
Or email to edinews.wcd@dcbs.oregon.gov