PAYER ID: 37259 SUBMITTER ID:

Change Healthcare ERA Provider Information Form

*This form is to ensure accuracy in updating the appropriate account

1 Provider Organization

Practice/ Facility Name		ProviderName			
Tax ID		Client ID		Site ID	
Address		City/State		Zip Code	
Contact Name					
E-mail Address		Telephone		Fax	

2 Vendor *(Change Healthcare certified vendor used to submit files to Change Healthcare)*

Vendor Name		Vendor Submitter ID		Division ID	
Contact Name					
E-mail Address					

3 Payer

Payer ID	37259 SAMBA	
Group ID	Individual Provider ID	NPI ID

4 Confirmations

Send Change Healthcare Claim Confirmations To:	

Special Instructions:

- **All Payer Registration forms must contain signatures when applicable, stamped signatures or photocopies are accepted.**
- **SUBMIT COMPLETED FORM TO:**
  Fax: (615) 231-4843
  Email: batchenrollment@Changeheatlhcare.com

REVISION FORM DATE: 01/05/16

SAMBA
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

Electronic Remittance Advice (ERA) Authorization Agreement

Page 1 – Definitions for DEG group data elements contained in Appendix.

DEG1	**PROVIDER INFORMATION**
Provider Name	
Doing Business As Name (DBA)	
Provider Address Street	
City	
State/Province	
Zip Code/Postal Code	

DEG2	**PROVIDER IDENTIFIERS INFORMATION**									
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)							37259			
National Provider Identifier (NPI)										

DEG3	**PROVIDER CONTACT INFORMATION**
Provider Contact Name	
Telephone Number	
Email Address	
Fax Number	

DEG7	**ELECTRONIC REMITTANCE ADVICE INFORMATION**									
Preference For Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier) - Select from below										
Provider Tax Identification Number (TIN)										
National Provider Identifier (NPI)										
Method of Retrieval	CLEARINGHOUSE									

DEG8	**ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION**
Clearinghouse Name	CHANGE HEALTHCARE
Clearinghouse Contact Name	ENROLLMENT HELP DESK
Telephone Number	866-924-4634
Email Address	payerregistration@changehealthcare.com

DEG10	**SUBMISSION INFORMATION**
Reasons For Submission – Select from below	

☐ **New Enrollment**

☐ **Change Enrollment**

☐ **Cancel Enrollment**

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Page 2 – Definitions for DEG group data elements contained in Appendix.

Authorized Signature	
Written Signature of Person Submitting Enrollment	
Printed Name of Person Submitting Enrollment	
Printed Title of Person Submitting Enrollment	