

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)*

VendorName		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:	
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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@Changehealthcare.com

REVISION FORM DATE:

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)											
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											
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Enrollment <input type="checkbox"/> Cancel Enrollment											



Electronic Remittance Advice (ERA) Authorization Agreement

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