835 Electronic Remittance Advice (Era) Enrollment Form

Please complete the following information:

☐ Activate Enrollment - Date: _____ **OR** ☐ Terminate Enrollment - Date: _____

Provider Name: _____

Provider Address: _____

City: _____ State: _____ Zip Code: _____

Provider Contact: _____ Provider Phone _____

Provider Tax Identification Number (TIN): _____

Provider National Provider Identifier (NPI): _____

Clearinghouse Name: _____

Vendor Name: _____

This authority is to remain in full force and effect until HealthPlan Services has received written notification from me on its termination in such time and such manner as to afford HealthPlan Services a reasonable time to act on notification.

Authorized Signature: _____ Date: _____

If the provider is a customer of Change Healthcare, enrollment forms can be completed at https://connectcenter.changehealthcare.com/ . If there are any questions, please contact Change Healthcare at 1-800-527-8133, option 1.

Electronic Remittance Advise (ERA) – New Enrollment

Revised Date 8/27/2024