



Change Healthcare ePayment Enrollment Authorization Request

Instructions

Providers can receive electronic payments by enrolling in Change Healthcare ePayment! If you have questions about this Change Healthcare ePayment Enrollment and Authorization Forms, or if you need help accessing Change Healthcare Payment Manager, please call **866.506.2830**. **Please allow for a 15 day validation period to process these EFT forms.**

Submit the following pages to confirm what type of EFT Enrollment Form you are wanting to complete and we will email you back with the Enrollment Form that you select below.

New ePayment Enrollment Authorization Form

Change Existing ePayment Banking

Deactivate Existing ePayment Banking

Add/Change/Delete EFT Payers

EFT Test Transaction Resubmission Form

Payment Manager Authorization Form

Provider Information

Provider Identifiers Information

* Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	
*All Group and Provider National Provider Identifier (NPI)	

Provider Information

* Provider Name			
Doing Business As Name (DBA)			
* Provider Address Street			
* City			
* State/Province			
* Zip Code/Postal Code			
* Country Code			
License Number			
License Issuer			
* Provider Type	Medical	Dental	Pharmacy
Provider Taxonomy Code			

Provider Contact Information 1

* Provider Contact Name			
* Title			
* Telephone Number			
Telephone Number Extension			
* Email Address			
Fax Number			

Provider Contact Information 2

* Provider Contact Name			
* Title			
* Telephone Number			
Telephone Number Extension			
* Email Address			
Fax Number			

Provider Agent Information

Provider Agent Name			
Provider Agent Address Street			
City			
State/Province			
Zip Code/Postal Code			
Country Code			
Provider Agent Contact Name			
Provider Agent Contact Title			
Telephone Number			
Telephone Number Extension			
Email Address			
Fax Number			

Change Healthcare ePayment Enrollment and Authorization Form Acknowledgement

By signing below, Provider acknowledges that the Provider has read, agrees that it is subject to and agrees to comply with the Change Healthcare General Terms and Conditions, the Business Associate Terms, the ePayment Services Addendum and the Privacy Policy for changehealthcare.com. To view the Change Healthcare General Terms and Conditions, the Business Associate Terms and the ePayment Services Addendum please visit: www.changehealthcare.com/epayment/terms. To view the Privacy Policy for changehealthcare.com, please visit www.changehealthcare.com/privacy. In addition, by signing below, Provider represents and warrants that all of the information that it is providing to Change Healthcare is accurate and complete. In furtherance of the ePayment Services, Provider authorizes Change Healthcare Solutions LLC or one of its Affiliates to initiate ACH debit and credit entries to the above account(s) at the above depository financial institution(s). Provider acknowledges that the origination of ACH transactions to the above account(s) must comply with the provisions of U.S. law. Provider also acknowledges that in the provision of the ePayment Services, the Provider's enrollment information may be made available to the Payers making payment to the Provider through the ePayment Services.

Provider desires to revoke or modify the authority of any Authorized Representative or add additional Authorized Representatives, Provider must execute and deliver to Change Healthcare a new ePayment enrollment authorization form. Letters or other forms of communications will not be accepted. Any subsequent ePayment enrollment authorization form supersedes any previously submitted ePayment enrollment authorization form. **CURRENT AUTHORIZED REPRESENTATIVES NOT ON THE ePayment enrollment authorization form WILL NOT BE RECOGNIZED.**

As required by 42 C.F.R. 455.18 and 455.19, I understand in accepting electronic payment that such payment may be from Federal and State Funds and any falsification or concealment of a material fact may be prosecuted under Federal law.

IN WITNESS WHEREOF, the parties have caused this Change Healthcare ePayment Enrollment and Authorization Form to be executed by their respective duly authorized representatives.

Submission Information

* Authorized Signature

*This form requires an original signature.
Stamps or e-signatures will not be
accepted.*

* Printed Title of Person Submitting Enrollment

* Submission Date

* Requested EFT Start / Change / Cancel Date