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.

☐ Carefirst New ePayment Enrollment Authorization Form

☐ Carefirst ePayment Bank Change Form

Email address that Change Healthcare will use to send the selected electronic request form.

Please sign, date & submit this EFT Enrollment Request

Email completed forms to EFTEnrollment@ChangeHealthcare.com or Fax it to 615-238-9615

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 submitting this form, 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: https://www.changehealthcare.com/terms-of-use/epayment. In addition, by submitting this form, 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

* Printed Name of Person Submitting Enrollment	
* Submission Date	
* Requested EFT Start / Change / Cancel Date	