

**1 Provider Organization**

Practice/Facility Name							
Tax ID				Billing NPI ID			
Practice/Facility Address				State			Zip Code
	City						
Contact Name				Contact Phone			
Provider Email							

**2 Vendor** *(Change Healthcare contracted & certified customer used to retrieve ERA files)*

Vendor Name				Submitter ID			
Contact Name				Contact Phone Number			

**3 ERA Receiver**

Receiver ID							
Distribution Method <i>(Must list one method)</i>				Distribution			

**4 Payer** *(If additional rows are required for payer ID selection, complete additional ERA Provider Setup Forms.)  
Following Payers MUST have Legacy ID's listed to complete Payer Enrollment: SB580-SB690-SKAR0-SKMD0*

Payer ID	Group ID	Individual ID	NPI ID	Payer ID	Group ID	Individual ID	NPI ID

**5 Confirmations** *(Enter E-mail address)*

**Confirmations** *(Enter E-mail address)*

**\*\*Section 1\*\*** Provider Organization section must be fully completed with Facility/Provider information, failure to complete all fields may result in form rejections. **Do not** list Vendor or Billing Service information. ERA payer enrollment requires that this information be that of the Facility/Provider as multiple payers will contact the Facility/Provider contact to confirm enrollment. These payers will not accept the confirmation of enrollment from Vendors or Billing Services. Billing NPI is **required** to complete enrollment.