



## 835 ENROLLMENT REQUEST (AAMG1/CCHCA)

Fax this completed form to AAMG at (415) 216-0092. Please make sure to print legibly and to complete this form in its entirety. You risk delaying enrollment if the application is unreadable or incomplete.

### PROVIDER INFORMATION:

**Provider Name:**

**Provider Address:**

### PROVIDER IDENTIFIER INFORMATION:

**Provider Federal Tax Identification Number (TIN)  
OR Employer Identification Number (EIN):**

**National Provider Identifier (NPI):**

### PROVIDER CONTACT INFORMATION:

**Provider Contact Name:**

**Telephone Number:**

**Fax Number:**

**Email Address:**

### ELECTRONIC REMITTANCE ADVICE INFORMATION:

**Preference for Aggregation  
Of Remittance Data:**

**Note:** Account Number Linkage to Provider Identifier. Must match preference for EFT payments.

### SUBMISSION INFORMATION:

**Reason for Submission:**

**Authorized Signature:**

**Note:** Electronic Signature (typed name) of Person Submitting ERA Enrollment.