

WHICH FORMS SHOULD I COMPLETE?

- Change Healthcare ERA Enrollment Form
- Assertus Provider Enrollment Form

WHERE SHOULD I SEND THE FORM(S)?

- Email the **Change Healthcare EDI Enrollment form** along with the **Assertus Provider Enrollment form** to batchenrollment@changehealthcare.com

WHAT IS THE TURNAROUND TIME?

- Standard Processing Time is approximately 14 days.

| Payer Information | | | | | |
|---------------------------------|----------------|-----------------|-------------------------|---------------|----------|
| CPID | Payer ID | Payer | Type | Est Days | Multi CH |
| | | | | | |
| Special Enrollment Instructions | | | | | |
| | | | | | |
| Vendor Information | | | | | |
| Submitter ID | Submitter Name | | | | |
| | | | | | |
| Provider Information | | | | | |
| Tax ID | NPI | Provider Number | Name | | |
| | | | | | |
| Address | | | City | State | Zip |
| | | | | | |
| Contact Name | | | | Contact Phone | |
| | | | | | |
| Contact Email Address | | | | | |
| | | | | | |
| Confirmation Addresses | | | | | |
| Primary Email Address | | | Secondary Email Address | | |
| | | | | | |
| ERA Receiver | | | | | |
| Distribution Detail | | | | | |
| | | | | | |



**PROVIDER ENROLLMENT
TRANSMISSION AUTHORIZATION**

By completing and signing this authorization, the healthcare Provider is authorizing Assertus Holdings, LLC to interchange its electronic Healthcare transactions with the Trading Partner acting as a Delegate Transmission Site for the Healthcare Provider as reported hereunder.

| | | | | | |
|---|---|--|--|-------------------------------|---|
| Delegate Transmission Site CHC1 | | Site Account Number 581651222 | | NPI | |
| Provider Name | | Phone () - Ext. | | Fax () - | |
| Type <input type="checkbox"/> Solo Practitioner <input type="checkbox"/> Group Practice | | Email | | | |
| Street Address | | Postal Address <input type="checkbox"/> Same as Street Address | | | |
| | | | | | |
| | - | | | | - |
| Notes: | | | | | |
| Authorization Hereby, I certify that I'm the Provider referenced above or an authorized representative and that the reported NPI on this form belongs to the Provider referenced above, and I authorize ASSERTUS Holdings, LLC for the interchange of related health care transactions thru the Delegate Transmission Site reported on this form. I understand that this authorization will remain active until canceled in writing. I also understand that it is my responsibility to monitor that every claims file submitted to Assertus has a positive confirmation receipt received and that I need to report to Assertus any missing confirmation receipts. | | | | | |
| Billing Provider Authorized Signature | | Date: | | ASSERTUS Authorized Signature | |
| | | | | Date: | |