CHANGE HEALTHCARE

Change of Vendor Procedures for ERA

A “change of vendor” (COV) letter is required when an existing Change Healthcare provider changes software vendors. The letter is required when the provider changes from their existing Change Healthcare certified software vendor (submitter id) to a different Change Healthcare certified software vendor (submitter id).

Any new ERA Provider Set-Up Form (PSF) sent to Change Healthcare that requires a Change of Vendor (COV) letter will be considered incomplete without the accompanying letter. Change Healthcare will notify the provider if the “change of vendor” letter is required but not received.

Following are steps required for a provider to change Change Healthcare certified software

vendors:

Step #1 Complete a Change of Vendor letter using the interactive template provided.

THE LETTER MUST BE PRINTED ON THE PROVIDER/SITE’S LETTERHEAD AND CONTAIN ALL INFORMATION LISTED IN THE BELOW TEMPLATE.

The Authorization letter (COV) must be signed and dated.

Step #2 Email to enrollmentcentral@changehealthcare.com or fax to 615.885.3713

This COV must be attached to a ERA Provider Set-Up Form (PSF)
http://www.changehealthcare.com/enrollment/index.php - Change Healthcare Set-Up Forms

Step #3 Change Healthcare will make the change in the appropriate Change Healthcare systems. Confirmation will be sent to the individual indicated within the ERA PSF when the set up is complete within 5 business days.

Step#4 If you are requesting spilt files you must submit a Merge Group ERA PSF with the COV LETTER.

Questions? Contact Change Healthcare Enrollment at: (866) 924-4634

Change Healthcare Enrollment Department
Attn: Enrollment Department – Merge Group ERA Set Up
enrollmentcentral@changehealthcare.com
Fax: 615.885.3713

Dear Change Healthcare:

Currently, I am receiving my Electronic Remittance Advice through

I would like to start receiving my Electronic Remittance Advice through Change Healthcare Corporation using

This change request will also include ALL PROVIDERS associated with this tax ID.

☐ Please carry over all payers associated with the below tax id with merge group.

☐ Please move only the payers listed on the attached ERA PSF with merge group.

Please accept this letter as my request to change vendors. Following is specific information regarding my practice:

Name:

Practice:

Address:

Phone #:

Contact:

Email:

Tax Id:

Sincerely,

Printed Name

Title

CHANGE HEALTHCARE

ERA Merge Group Provider Setup Form

Email: enrollmentcentral@changehealthcare.com

Fax: (615)885-3713

1 Provider Organization

Provider Name					
Tax ID		**Billing NPI ID**			
Provider Address					
	City		**State**	**Zip Code**	
Contact Name		**Telephone**			
Provider Email					

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

Vendor Name		**Submitter ID**	
Contact Name		**Telephone**	

3 Receiver

Receiver ID		
How do you want your Era file split?		
Distribution Method (Must list one method in the distribution field below)		**Default Distribution**

4 Payers (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	Distribution (list if using option other then default)

5	**Send Confirmations To:**	
	Send Confirmations To:	