Feel Well,
Live Well with
AgeWell
NEW YORK

EFT/ERA REQUEST FORM

General Information: ☐ NEW Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Requested Effective Date (1): _____

Provider Name: _____

Provider Contact Name: _____

Provider Address: _____

Contact Phone #: _____

Contact Email: _____

Tax ID Number: _____

All applicable Billing/Pay to NPI: _____

Bank Information: ☐ Check box if EFT is requested:

ACH Routing Number (ABA#): _____

Bank Account Number: _____

Bank Name: _____

Bank Address: _____

Check one ☐ **Savings** ☐ **Checking**

☐ Check box if 835 is requested:

Method of Retrieval	
ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION (if Applicable)	
Clearinghouse Name	
Clearinghouse Contact Name	
Telephone Number	
Email Address	

Please Note: Paper SOR will be discontinued 90 days after 835 setup has been completed.

Form Completed By: _____ Date: _____

(1) 30 days is needed to process a request.
(2) Please attach a copy of a voided check and a W9.
(3) Email to: Batchenrollment@changehealthcare.com or Fax to: (615) 885-3713