Send completed form to:
Batchenrollment@changehealthcare.com
Fax: (615) 885-3713

Remittance

Payer Information					
CPID	**Payer ID**	**Payer**	**Type**	**Est Days**	**Multi CH**
6720	L0230	CareFirst BlueCross BlueShield Community Health Plan District of Columbia (CareFirst CHPDC)	Professional	5	No

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

For Change Healthcare use only

Email