ERA Enrollment Form

Please write clearly and email the completed form to **edi@vivanthealth.com**

Provider's clearinghouse (select from the following):
- ☐ Office All
- ☐ Change (Relay)
- ☐ Change (Emdeon)
- ☐ eSolutions (ClaimRemedi)

Payer ID used for Vivant Health: _____

Organization/provider name: _____

Organization/provider address: _____

City: _____

Provider federal Tax Identification Number (TIN): _____

National Provider Identifier (payee NPI for ERA): _____

Tax ID (TIN): _____

Contact

Name: _____

Title: _____

Telephone number/extension: _____

Email address: _____

Fax number: _____

Authorized signature: _____

Note: Electronic signature (typed name) of person submitting era enrollment.

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