



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

## Remittance

Payer Information						
CPID	Payer ID	Payer	Type	Est Days	Multi CH	
2845	13407	SVCMC, Inc.	Professional	5		
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						