**CareFirst BlueCross BlueShield**
**Community Health Plan**
**District of Columbia**
1100 New Jersey Ave. SE
Suite 840
Washington, D.C. 20003
www.carefirstchpdc.com

Hello Provider,

Thank You for becoming a provider in the CareFirst BlueCross BlueShield Community Health Plan District of Columbia (CareFirst CHPDC) formerly known as Trusted Health Plan (District of Columbia), Inc. Provider Network. 835 ERAS' are in production for CareFirst CHPDC through Change HealthCare. Please find attached the information needed to enroll for 835 ERA files with Change HealthCare. If you use a clearinghouse other than Change HealthCare, you will have to complete the enrollment through your clearing house, and they will handle the set up with Change HealthCare. If you utilize Change HealthCare as your clearinghouse you may enroll directly through Change HealthCare.

In addition, EFT's are also now in production please find attached the form for EFT enrollment with CareFirst CHPDC.

Please return completed EFT enrollment forms to:

**CareFirst BlueCross BlueShield Community Health Plan District of Columbia**
**Attn: Provider Relations**
1100 New Jersey Avenue
SE Suite 840
Washington, D.C. 20003
Phone: 202-821-1145
Fax: 202-905-0178

Please note that you must be actively enrolled and receiving ERAS' prior to being set up for EFT's. Once an enrollment confirmation is received from Change HealthCare you will be set up for ERA's, you must notify CareFirst CHPDC when you receive the ERAs' so that your application for EFT set up can be submitted.

Much Appreciated,

***CareFirst CHPDC Provider Relations***

This program is funded in part by the Government of the District of Columbia Department of Health Care Finance.

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CareFirst Community Health Plan District of Columbia

# Authorization Form for Electronic Funds Transfer (EFT)

**Section 1**

All fields must be completed

| Vendor Name: | | |
|---|---|---|
| Contact Name: | | |
| NPI Number: | | |
| Federal Tax ID Number: | | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | |
| Email address: | | |

**Section 2**

Bank information

| Bank Name: |
|---|
| Branch Address: |
| Bank Routing Number: |
| Bank Account number: |
| Type of Account (Checking, Saving, Money Market, etc.): |

**Section 3**

To be completed by CFO or Authorized Representative(s)

| I confirm the identity of the above vendor, name, provider number, tax ID, account number and routing number. As a representative of the above-named vendor, I certify that the information provided is correct and the provider approved the direct deposit option. | |
|---|---|
| Representative Name: | |
| Representative Title: | |
| Phone Number: | Email: |
| Signature: | Date: |

Joint account holder certification (if applicable)

| Name: | |
|---|---|
| Title: | |
| Phone: | Email: |
| Signature: | Date: |

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