DELTA DENTAL

Provider Direct Deposit Enrollment Form

Please fax or email this form to:
(f) 303.741.2230 Attn: Provider Relations
(e) profservices677@ddpco.com

Reason for Submission

☐ **New EFT/ERA Authorization:** Complete sections A, B, C, D, & E ☐ **Cancel EFT/ERA:** Complete sections A & G

☐ National EFT(All Delta Dental) ☐ Local EFT (Colorado Only)

☐ **Changes to an existing EFT/ERA Authorization:** Complete sections A, B, C, E, F, and H

☐ National EFT(All Delta Dental) ☐ Local EFT (Colorado Only)

A. Provider Information

Provider's Complete Legal Name: Practice Name:

Address: City: State: Zip:

Phone Number: Fax Number:

Name of Office Contact: Provider's Email Address:

National Provider Identifier (NPI1) if applicable:

*Provider Tax Identification Number (TIN): Provider License Number: Issuing State:

Please indicate which locations you would like to have this Direct Deposit Form include:

☐ Only this location ☐ All locations ☐ I will attach the address of the locations

B. Banking/Financial Institution Information (Please print or type)

Financial Institution's Name: Account Number: Routing Number:

Address: City: State: Zip:

Telephone Number: Type of Account: ☐ Checking ☐ Savings

Account Number Linkage to Provider ID: ☐ Provider TIN ☐ NPI

C. ERA Enrollments (Coming in 2017)

Are you planning on using a clearing house (ex: Tesia/Change Healthcare) to receive your ERA? ☐ Yes ☐ No

If yes, please provide the clearing house name: _____

You will receive the ERA via the website. Contact your finanical institution to arrange for the delivery of the CORE-related Minimum CCD + Data Elements necessary for successful re-association of the EFT payment with the ERA remittance advice.

D. EFT/ERA Consent

In consideration for the provision of direct deposit services, by signing below, and not withstanding any language to the contrary herein, you hereby acknowledge and agree that (i) any information you have provided, including but not limited to, the information you supplied under the heading "Banking/Financial Institution Information" above, may be transferred, shared or otherwise provided by us to or with any entity that is an affiliate of Delta Dental, as defined above, with other Delta Dental member companies and their affiliates, and with Delta Dental Plans Association, for use in connection with funds to be deposited to your account, (ii) any election to discontinue enrollment in this direct deposit program will take thirty (30) business days to process, and may not be effective to halt any deposits that were initiated while your enrollment in this direct deposit programwas in effect, and (iii) in the absence of gross negligence or willful misconduct, neither we, any of our members and affiliates, other Delta Dental member companies and their affiliates, or Delta Dental Plans Association, will be responsible for any damages, or for any fee, charge, or other expense assessed against the Bank Account identified above, in connection with this direct deposit program. Further, by signing below, you represent and warrant that (i) all of the information you supplied is true and accurate, (ii) the information provided under the heading "Banking/Financial Institution Information," above, identifies a bank account held by the Business you identified above, and (iii) the signatory to this Direct Deposit Enrollment Form ("Form") has all necessary power and authority to execute this Form.

E. New Authorization

I authorize and request Delta Dental of Colorado (hereinafter called DDCO) to send the net claims check directly to my bank or other financial institution as specified in Section B of this form. I understand that by doing this, I will begin receiving an ERA statement as an explanation of benefits (EOB). I understand I may terminate this agreement at any time by completing another "Direct Deposit Authorization" or in any event by sending a thirty (30) day written notice to terminate (with new request/instructions for future payment).

Dentist Signature: _____ Date Signed: _____

F. Change Authorization Statement

I authorize and request DDCO to make the changes indicated on this form. I will allow DDCO thirty (30) days from date of receipt of this document to accomplish these changes.

Dentist Signature: _____ Date Signed: _____

G. Cancellation Statement

I authorize and request DDCO to terminate authorized direct deposits to my account. By doing this, I understand that I will no longer receive an Explanation of Benefits (EOB) through an ERA statement. I understand that all future payments will be made via a paper check and that ERA statements will come in the form of a paper EOB. I will allow DDCO a thirty (30) day notice from receipt date of this document to accomplish these changes. Unless otherwise noted, upon such cancellation (future) payments will be made to the participating dentist.

Dentist Signature: _____ Date Signed: _____

H. This step is EXTREMELY important, as your application cannot be processed without a voided check.

Please mark the validation attached/scanned: ☐ A voided check ☐ Your bank's letterhead with account & routing numbers

A voided check is not required if there are no changes to your Banking/Financial Institution information.