DELTA DENTAL
AUTHORIZATION for DISBURSAL, CHANGE, or CANCELLATION of
DIRECT DEPOSIT

The undersigned dentist and/or group dental practice hereby request and authorize **Delta Dental** to credit their bank account by Direct Deposit/Electronic Funds Transfer (EFT) and provide Explanation of Benefits (EOB) access or Electronic Remittance Advice (ERA) for the agreed upon dollar amounts and dates.

You may request Direct Deposit solely from Delta Dental of Massachusetts (DDMA) [1], or from all Delta Dentals with EFT capabilities. If you choose Direct Deposit from all Delta Dentals, then you must authorize DDMA to share your Direct Deposit Banking Information with the Delta Dental Plans Association (DDPA) and out-of-state Delta Dentals.

INSTRUCTIONS:

1. Check the appropriate option(s) **A**, **B**, **C**, **D** below and then complete all parts of this form.
2. Execute signatures. If account requires counter signatures, both signatures must appear on this form. Form must be signed by the Owner or Executive who can bind the Organization.
3. Attach a voided check from your checking account, or letter from your bank indicating your company name, account number, and routing number (for accounts for which a voided check cannot be provided).
4. Send the completed form and voided check (or bank letter) to Delta Dental of Massachusetts (DDMA).
   Via Fax: (617) 886-1414 or **Via E-Mail: DeltaDentalCredentialingUpdates@greatdentalplans.com**

ACTION AUTHORIZED BY DENTAL OFFICE: ____ / ____ / _____
(EFFECTIVE DATE)

☐ **A**

I only want to receive direct deposit from DDMA. I will access Explanations of Benefits (EOBs) from the DDMA website www.deltadentalma.com.

I do not want to receive direct deposit from Delta Dentals Plans other than DDMA.

☐ **B**

I want to receive Direct Deposit from all Delta Dentals that have Direct Deposit capabilities. Please share my Direct Deposit Banking Information record with Delta Dentals of every state via DDPA.

I will access Direct Deposit payment information by logging onto the DDPA website www.deltadental.com, where payment information is made available two different ways:

1. **Clicking on "View Delta Dental ERAs" to access payment information on the DentalXChange webpage, which displays ERA payment information from most Delta Dentals.**
2. **Clicking on the individual Delta Dental website links which will be displayed for the few Delta Dentals that do not yet have DentalXChange capabilities.**

Note: DDMA submission of 835 transaction directly to the provider's clearinghouse or practice management software is not available with this option.

☐ **C**

Change Existing EFT Bank Account or EFT/ERA Option (select new option above and complete form).

☐ **D**

Delete Existing Dental Office Direct Deposit/EFT/ERA Registration.

Note: Cancellation will make this practice location ineligible for "Incentive Fee Schedules".

[1] For purposes of this document, "Delta Dental of Massachusetts" or "DDMA" means Dental Service of Massachusetts, Inc. ("DSM") or DSM Massachusetts Insurance Company, Inc. ("DMIC") both of which entities do business as Delta Dental of Massachusetts), as applicable, or an entity controlled by, controlling or under common control with, and acting on behalf of, one or both of these entities Delta Dental of Massachusetts is an Independent Licensee of the Delta Dental Plans Association.

DELTA DENTAL

AUTHORIZATION TO HONOR DIRECT AUTOMATED CLEARING HOUSE (ACH) CREDITS
DISBURSED BY Delta Dental of Massachusetts

***Indicates Required Field. Please print legibly.**

Provider Information			
*Provider Name – Complete legal name of corporate entity, practice or individual provider		Doing Business As (DBA)	
Provider Address			
*Street		*City	
*State/Province		*ZIP Code /Postal Code	

Provider Identifiers Information			
*Provider Federal Tax ID (TIN) or Employer Identification Number (EIN) Numeric 9 Digits		*National Provider Identifier (NPI) Numeric 10 Digits	

Provider Contact Information			
*Provider Contact Name- (Owner or Executive who can bind Organization)		Title	
*Telephone Number		*Email Address	

Financial Institution Information			
*Financial Institution Name			
Financial Institution Address			
*Street		*City	
*State/Province		*Zip Code/Postal Code	
Financial Institution Telephone Number		Financial Institution Fax Number	
*Financial Institution Routing Number (Numeric 9 Digits)		*Type of Account at Financial Institution (e.g., Checking, Saving)	
*Provider's Account Number with Financial Institution		*Account Number Linkage to Provider Identifier – Select One	Provider TIN ☐ Provider NPI ☐

Submission Information			
***Reason for Submission** Select One	**New Enrollment** ☐	**Change Enrollment** ☐	**Cancel Enrollment** ☐
Include with Enrollment Submission	Voided Check A voided check is attached to provide confirmation of Identification/Account Numbers		

As a convenience to me, for payment of services or goods due to me, I hereby request and authorize **Delta Dental of Massachusetts** to credit my bank account via Direct Deposit for the agreed upon dollar amounts and dates. I also agree to accept my remittance statements online and understand paper remittance statements will no longer be processed.

This authorization will remain in effect until revoked by me in writing. I agree **Delta Dental of Massachusetts** shall be fully protected in honoring any such credit entry.

I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.

I agree that **Delta Dental of Massachusetts'** treatment of each such credit entry, and the rights in respect to it, shall be the same as if it were signed by me. I fully agree that if any such credit entry be dishonored, whether with or without cause, **Delta Dental of Massachusetts** shall be under no liability whatsoever.

Submission Date

Authorized Signature

Requested EFT Start/Change/Cancel Date

Printed Name of Person Submitting Enrollment

Printed Title of Person Submitting Enrollment

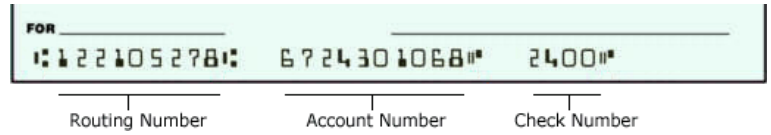
APPENDIX

Additional Information to assist with completion of this EFT/ACH Enrollment Form and the EFT/ACH banking process.

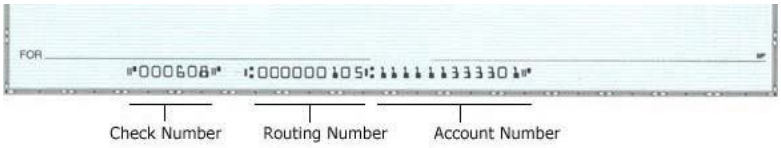
Please note the following *IMPORTANT* information:

- We are required to inform you that you MUST contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the ERA.
- **You MUST attach a voided check from your account.**

ACCOUNT HOLDER INFORMATION:



Personal Checking Example



Business Checking Example

Questions?

You may send your completed form, as well as any questions regarding the status of your EFT enrollment, to the fax number or email address provided below:

Fax: (617) 886-1414

Email: DeltaDentalCredentialingUpdates@greatdentalplans.com