DELTA DENTAL®

Direct Deposit Enrollment Form

For Delta Dental of Kansas Participating Dentists Only

REASON FOR SUBMISSION

- ☐ **New NATIONAL EFT/ERA Direct Deposit Authorization:** Complete sections A, B, C, D, G and H
- ☐ **New LOCAL (KS ONLY) EFT/ERA Direct Deposit Authorization:** Complete sections A, B, C, D, G and H
- ☐ **Changes to an Existing EFT/ERA Authorization:** Complete sections A, B, D, E, G and H
- ☐ **Cancel EFT/ERA:** Complete sections A, F and G

A. PRACTICE / LOCATION INFORMATION & ELECTRONIC REMITTANCE ADVICE (ERA) RETRIEVAL

Practice Name: _____ Practice Owner's Name: _____

Practice Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Name of Office Contact: _____

Office Email Address: _____

National Provider Identifier (NPI Type 2 - Organization): _____
(Required)

Practice Tax Identification Number (TIN): _____

This enrollment is for all dentists who practice under the TIN provided above. Please indicate which locations you would like to have this Direct Deposit Form include:

☐ Only this location ☐ All locations *(Required: Please attach the addresses of all locations.)*

Both Local (KS ONLY) and National ERAs will be available online through your dentist account at DeltaDentalKS.com. For Local (KS ONLY) ERAs, you will receive an email notification sent to the email provided below when an ERA is available.

Email Address for ERA Notification: _____

B. BANKING/FINANCIAL INSTITUTION INFORMATION *(please print or type)*

Financial Institution's Name: _____

Routing Number: _____ Account Number: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Type of Account: ☐ Checking ☐ Savings

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C. EFT/ERA CONSENT

In consideration for the provision of direct deposit services, by signing below, and notwithstanding 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 program was 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.

D. NEW AUTHORIZATION

☐ I authorize and request Delta Dental of Kansas (hereinafter referred to as DDKS) 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 "EFT Direct Deposit Enrollment Form" or in any event, by sending a thirty (30) day written notice to terminate (with new request/instructions for future payment).

E. CHANGE AUTHORIZATION

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

F. CANCELLATION

I authorize and request DDKS 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 DDKS 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.

☐ Cancel National & Local (KS ONLY) EFT Enrollment

☐ Cancel National EFT Enrollment ONLY
Practice will stay enrolled in Local (KS ONLY) EFT

G. AUTHORIZATION SIGNATURE

I authorize and request Delta Dental of Kansas to take appropriate action based on the selection(s) made above. I will allow DDKS thirty (30) days from date of receipt of this document to accomplish this.

Practice Owner's Signature: _____ Date: _____

H. BANKING/FINANCIAL INSTITUTION INFORMATION REQUIRED FOR VALIDATION.*

Please indicate the validation attached/scanned:

☐ A voided check ☐ Your bank's letterhead with account & routing numbers

***Validation is not required if your practice is currently enrolled and there are no changes to your Banking/Financial Institution information.**

Return to Delta Dental of Kansas:
email: pr@deltadentalks.com | fax: 316.462.3317
mail: Attn: Professional Relations, P.O. Box 789769 Wichita, KS 67278-9769

316.264.1099 | DeltaDentalKS.com