Direct Deposit Enrollment Form

This Form is for Delta Dental of Kansas Participating Dentists

REASON FOR SUBMISSION

☐ **New EFT/ERA Authorization:** Must complete sections A, B, C, D and E*

☐ National & Local EFT ☐ Local EFT only

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

☐ National & Local EFT ☐ Local EFT only

☐ **Cancel EFT/ERA:** Must complete sections A and G*

A. DENTIST INFORMATION

Dentist's Complete Legal Name: _____ Practice Name: _____

Practice Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Name of Office Contact: _____ Office's Email Address: _____

National Provider Identifier (NPI): _____ Assigning Authority: _____
(if applicable)

**Dentist Tax Identification Number (TIN): _____ Dentist License Number: _____ Issuing State: _____
(please abbv.)

****All locations listed under this TIN will be enrolled unless otherwise noted. If you do not wish to have all locations enrolled, please include a list of the locations you wish to have enrolled.**

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

Institution's Name: _____

Bank Routing Number: _____ Account Number: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Type of Account: ☐ Checking ☐ Savings ☐ Other: _____
(please specify account type)

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

C. ERA ENROLLMENTS

Both Local and National ERAs will be available online through your Dentist account at DeltaDentalKS.com. For local ERAs, you will receive an email notification sent to the email provided in Section A when an ERA is available.

To access local ERAs, you will need additional Login Credentials *(save your login credentials so you can access your local ERAs once you are setup in the system. Please note, this information should be kept confidential)*:

Username: Your TIN *(no spaces or dashes)*

Password: _____
(password requires a minimum of eight (8) and maximum of fifteen (15) and at least one uppercase letter, one lowercase letter and one number)

Return to Delta Dental of Kansas:
Attn: CONTROLLER mail: P.O. Box 789769 Wichita, KS 67278-9769 | fax: 316.462.3331

316.264.1099 | DeltaDentalKS.com

*All applicable sections must be completed before this form can be processed. If all applicable sections are not completed, the form may be returned for further completion.

Revision Date 2/2019

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D. 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 Section B on pg. 1, 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 on pg. 1, 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 Section B on pg. 1, identifies a bank account held by the Business you identified on pg. 1, and (iii) the signatory to this Direct Deposit Enrollment Form ("Form") has all necessary power and authority to execute this Form.

Dentist Signature:_____ Date:_____

E. 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 payment ("EOP"). I understand I may terminate this agreement at any time by completing another "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).

Dentist Signature:_____ Date:_____

F. CHANGE AUTHORIZATION STATEMENT

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.

Dentist Signature:_____ Date:_____

G. CANCELLATION STATEMENT

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 payment (EOP) 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 EOP. 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.

Dentist Signature:_____ Date:_____

H. THIS STEP IS EXTREMELY IMPORTANT, AS YOUR BANKING/FINANCIAL INSTITUTION INFORMATION CANNOT BE PROCESSED WITHOUT VALIDATION.***

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

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

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