

## Delta Dental of New Jersey and Connecticut Electronic Funds Transfer/Direct Deposit

*\*Now including Electronic EOBs\**

### Authorization Agreement – Instructions and Enrollment Form

Electronic Funds Transfer (EFT) allows Delta Dental member companies and their affiliates to send payment directly to your bank account. Explanations of Benefits will no longer be sent to you via the United States Postal Service, now offering a one stop solution for your Delta Dental patient’s EOBs using our National Portal.

EFT is applicable to all providers at the Business (Tax Identification Number)/ Service Office indicated on your application unless otherwise noted.

Please note that changes in your Tax Identification Number or Service Office address will terminate your EFT for that office; please complete a new EFT Authorization Agreement when modifying business information.

General Instructions	<p>EFT Enrollment is applied to all providers at the specified business service office. You can add one or more business service offices for the Tax Identification Number or Employee Identification Number entered.</p> <p>A copy of a voided check or a bank letter must be forwarded to the address, email or fax number below in order to complete your EFT enrollment.</p>
Delta Dental of New Jersey contact information	<p>Delta Dental of New Jersey, Inc. Professional Services Department PO Box 222 Parsippany, New Jersey 07054 Phone: 800-494-4137 Fax: 973-285-4192 Email: <a href="mailto:professionalservices@deltadentalnj.com">professionalservices@deltadentalnj.com</a></p>
Enrollment Confirmation	<p>Delta Dental of New Jersey will confirm requests for new enrollments, changes in enrollment and enrollment cancellations in writing. Please allow up to thirty days (30) to complete EFT enrollment, modifications and/or banking changes.</p>
Changes to EFT Enrollment	<p>Complete the Authorization Agreement – Enrollment Form for all changes; you must indicate the reason for submission under Submission Information (last page).</p>
Electronic Remittance Advice (ERA) Electronic EOBs	<p>Enrollment includes access to your patients electronic EOBs across all Delta Dental Member Companies nationwide.</p> <p>Once enrolled, log into DeltaDental.com (Use the same ID and password you use on DeltaDentalNJ.com). A list of the state plans currently participating is available after login at DeltaDental.com. For your Delta Dental of NJ and CT patients only, you may contact using Benefits Connection to access patient information.</p>

**Delta Dental of New Jersey and Connecticut**  
**Electronic Funds Transfer/Direct Deposit**  
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All fields must be completed unless otherwise noted

**PROVIDER INFORMATION**

<b>Provider Name</b> _____			
<b>Provider Address</b> _____			
(Street)	(City)	(State/Province)	(ZIP Code/Postal Code)

**PROVIDER IDENTIFIERS INFORMATION**

<b>Provider Identifiers</b> _____ Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) _____ National Provider Identifier (NPI)
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**PROVIDER CONTACT INFORMATION**

<b>Provider Contact Name</b>		
_____ First Name	_____ Last Name	_____ Title
_____ Telephone Number	_____ Telephone Number Extension (if applicable)	
_____ Fax Telephone Number	_____ Email Address	

**FINANCIAL INSTITUTION INFORMATION**

<b>Financial Institution Name</b> _____
<b>Financial Institution Routing Number</b> _____
<b>Type of Account at Financial Institution:</b> _____ <b>Checking</b> _____ <b>Savings</b>
<b>Provider's Account Number with Financial Institution</b> _____
<b>Account Number Linkage to Provider Identifier</b> _____
Provider Federal Tax Identification Number (TIN) or National Provider Identifier (NPI) _____

**SUBMISSION INFORMATION**

**Reason for Submission**

(check one) \_\_\_\_\_ New Enrollment      \_\_\_\_\_ Change Enrollment      \_\_\_\_\_ Cancel Enrollment

**Include with Enrollment Submission**

(check one) \_\_\_\_\_ Voided Check  
\_\_\_\_\_ Bank Letter (A letter on bank letterhead that formally certifies the account owners' routing and account numbers)

**Authorized Signature** (The signature of an individual authorized by the provider or its agent to initiate, modify, or terminate an enrollment)

In consideration for the provision of direct deposit services, by signing above, I authorize Electronic Funds Transfer from Delta Dental of New Jersey, Inc. (on behalf of Delta Dental of New Jersey, Inc., other Delta Dental member companies and their affiliates) to direct payments to the bank account indicated above and confirm I will no longer receive paper EOBs from Delta Dental.

I understand that (a) this authorization extends to all payments due to this Authorizing Entity for all providers associated to its TIN or EIN and at the service office(s) listed above; and (b) the information provided above is subject to an audit at the discretion of Delta Dental of New Jersey, Inc.

Delta Dental member companies and their affiliates will not be responsible for any damages, or any fee, charge or other expense assessed against the Bank Account identified above, in connection with this direct deposit program.

This authority is to remain in full force and effective until Delta Dental of New Jersey, Inc. receives written notification from the authorized signee of its termination in such time and manner as to afford Delta Dental of New Jersey, Inc. reasonable opportunity to act on it.

\_\_\_\_\_  
Written Signature of Person Submitting Enrollment

\_\_\_\_\_  
Printed Name of Person Submitting Enrollment

**Submission Date**

\_\_\_\_\_

**Delta Dental of New Jersey Administrative Use Only:**

\_\_\_\_\_  
Tax Identificaton #

\_\_\_\_\_  
State

\_\_\_\_\_  
DDNJ Representative Initials

\_\_\_\_\_  
Date