



Delta Dental of Massachusetts

Attention Providers:

In order to start receiving your ERAs for Delta Dental of Massachusetts through EDS, you will need to visit <http://www.deltadentalma.com/era-enrollment/> and complete the online ERA application. Once you have completed the online application please complete the attached ERA ERA application.

Payer:	Delta Dental of Massachusetts
Payer ID:	04614
For Enrollment Questions:	Contact the EDS Enrollment Department at (800)482-3518 or Enrollment@edsedi.com
Online Enrollment Process:	<p>To enroll please go to http://www.deltadentalma.com/era-enrollment/ Under Method of Retrieval please select Clearinghouse from the drop down box. You will then enter the clearinghouse information.</p> <ul style="list-style-type: none">• Clearinghouse: DentalXChange• Clearinghouse Contact Name: Enrollment• Telephone Number: 800-576-6412• Email: enrollment@dentalxchange.com <p>Please select do not have Trading Partner Agreement</p>
Email or Fax Application to:	Enrollment@edsedi.com Fax (800) 389-9152
Approval Process and Timeframes:	An email is sent out to the provider's office to confirm that Delta Dental of Massachusetts received your request. You will receive a second to let you know they have completed the setup. Paper EOBs will be shut off upon approval. Payer estimates 30 business days for processing.



Electronic Remittance Advice (ERA) Authorization Agreement

To start receiving your ERAs from the payer through EDS you will need to follow the instructions below. (* indicates required field)

* Payer Name							
A. Provider Information							
*Provider Name							
*Provider Address							
Street:							
City:			State/Province:		Zip Code/Postal Code:		
B. Provider Identifiers Information							
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)							
National Provider Identifier (NPI)							
C. Provider Contact Name							
*Contact							
*Telephone Number							
*Email Address							
D. Electronic Remittance Advice Information							
*Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)							
<input type="checkbox"/> Provider Tax Identification Number (TIN)							
<input type="checkbox"/> National Provider Identifier (NPI)							
D. Submission Information							
*Reason for Submission							
<input type="checkbox"/> New Enrollment		<input type="checkbox"/> Change Enrollment		<input type="checkbox"/> Cancel Enrollment			
Authorized Signature							

Electronic or Printed Signature of Person Submitting Enrollment

Title of Person Submitting Enrollment

400 Vermillion St. Hastings MN 55033