Delta Dental of Wisconsin

Attention Providers:

To start receiving ERAs electronically from Delta Dental of Wisconsin, you will need to print and review the enrollment form. Please sign the form and submit to EDS using one of the methods below.

Payer:	Delta Dental of Wisconsin
Payer ID:	39069
For Enrollment Questions:	Contact the EDS Enrollment Department at (800) 482-3518 or Enrollment@edsedi.com
Payer Enrollment Applications:	**Electronic Transfer of Funds (EFT)/Direct Deposit and 835 – Electronic Remittance Advice (ERA) Authorization**
Upload, Email or Fax Application to:	Enrollment@edsedi.com or Fax (800) 389-9152
Approval Process and Timeframes:	Payer estimates 10-15 business days from date of submission.
Special Instructions:	**Delta Dental of Wisconsin requires EFT Enrollment in order to receive your ERAs electronically. Once the provider has been approved to receive ERAs, they will no longer receive paper EOBs.**

Delta Dental of Wisconsin:
Electronic Remittance Advice (ERA)/835
Authorization Agreement – Instructions and Enrollment Form

Special Notes	**Participation in Dental Electronic Remittance Advice (ERA)/835 is limited to those providers whose practice management software vendor is participating in ERA with one of the clearinghouses listed on page 2.** **Please contact your practice management software vendor for more details.** **Participation in ERA is further limited to those providers who participate in Electronic Funds Transfer (EFT)/Direct Deposit. If you are not yet an EFT participant, please also complete the EFT enrollment form on page 3.**
Where to submit your completed enrollment form	**Please contact your practice management software vendor for information on how and where to submit your enrollment form.**
Delta Dental of Wisconsin contact information	**Delta Dental of Wisconsin** **Professional Services Department** **PO Box 828** **Stevens Point, WI 54481** **800-836-0490** **Fax 715-343-7611** **pr@deltadentalwi.com**
Enrollment Confirmation	**Once enrollment processes are complete, Delta Dental of Wisconsin will notify the provider via email or fax to confirm the ERA start date.**
Late or missing ERA or EFT	**If your expected ERA or EFT appears to be late or missing, please contact Delta Dental of Wisconsin's Professional Services Department at 800-836-0490 or pr@deltadentalwi.com.**

Delta Dental of Wisconsin Administrative Use Only:

_____ _____ _____ OR _____ _____ _____

Dentist License Number | State | Office Location Number | Clinic Number | DDWI Representative Initials | date

Electronic Remittance Advice (ERA)/835 Enrollment Form

PROVIDER INFORMATION

Provider Name

_____

Provider Address

_____

(Street) (City) (State) (ZIP Code)

PROVIDER IDENTIFIERS INFORMATION

Provider Identifiers

_____

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

_____ _____

National Provider Identifier (Individual Provider - NPI1) National Provider Identifier (Organizational Provider - NPI2)

PROVIDER CONTACT INFORMATION

Provider Contact Name

_____

_____ _____

Telephone Number Email Address

ELECTRONIC REMITTANCE ADVICE INFORMATION

Preference for Aggregation of Remittance Data: Remittance Data is aggregated by Provider Tax Identification Number (TIN).

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

Clearinghouse Name

(check one) _____ emdeon® _____✔_____ EHG

ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION

Vendor Name

(Please provide the name of your practice management software vendor.) _____ _____

SUBMISSION INFORMATION

Reason for Submission

(check one) _____☐_____ New Enrollment _____☐_____ Change Enrollment _____☐_____ Cancel Enrollment

Authorized Signature (The signature of an individual authorized by the provider or its agent to initiate, modify, or terminate an enrolllment)
This authority is to remain in full force and effective until Delta Dental of Wisconsin Inc. receives written notification from me/us of its termination in such time and manner as to afford DDWI reasonable opportunity to act on it.

_____

Written Signature of Person Submitting Enrollment

_____

Printed Name of Person Submitting Enrollment

Submission Date **Requested ERA Effective Date**

_____ _____

Participation in ERA is limited to those providers who participate in Electronic Funds Transfer (EFT)/Direct Deposit with Delta Dental of Wisconsin.

- If you are currently enrolled in EFT with Delta Dental of Wisconsin, please check the statement below.

☐ **I am currently enrolled in EFT with Delta Dental of Wisconsin.**

- If you are NOT currently enrolled in EFT with Delta Dental of Wisconsin, you must complete the Electronic Funds Transfer (EFT)/Direct Deposit Enrollment form below to be eligible for ERA.

Electronic Funds Transfer (EFT) / Direct Deposit Enrollment Form

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

_____

Financial Institution Telephone Number

_____

Financial Institution Routing Number

_____

Type of Account at Financial Institution: ☐ **Checking** ☐ **Savings**

Provider's Account Number with Financial Institution

_____

Account Number Linkage to Provider Identifier

_____

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

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 enrolllment)
This authority is to remain in full force and effective until Delta Dental of Wisconsin Inc. receives written notification from me/us of its termination in such time and manner as to afford DDWI reasonable opportunity to act on it.

_____

Written Signature of Person Submitting Enrollment

_____

Printed Name of Person Submitting Enrollment

Submission Date _____ **Requested EFT Start/Change/Cancel Date** _____

EXPLANATION OF PAYMENT (EOP) DELIVERY OPTIONS

Select Delivery Option (choose one):

☐ E-mail notification with delivery of Explanation of Payment to Delta Dental's website

_____

E-mail to receive direct deposit notification

☐ Fax delivery of Explanation of Payment

_____

Fax Number to receive EOP