ERA Enrollment Instructions

INSTATE PROVIDERS ONLY - DO NOT COMPLETE IF NOT IN THE STATE OF WASHINGTON

Delta Dental of Washington

Attention Providers:

In order to start receiving your ERAs for Delta Dental of Washington through EDS, you will need to follow the below instructions required by the payer.

Payer:	Delta Dental of Washington IN-STATE PROVIDERS ONLY
Payer ID:	91062
For Enrollment Questions:	Contact the EDS Enrollment Department at (800) 482-3518 or Enrollment@edsedi.com
Enrollment Application:	**Electronic Remittance Advice (ERA) Authorization Agreement and Direct Deposit Authorization**
Email or Fax Application to:	Enrollment@edsedi.com Fax (800) 482-3518
Approval Process and Timeframes:	Payer estimates 5-7 business days from the date of submission. EDS will notify you once enrollment is complete.
Special Instructions:	**ERA Enrollment is for in-state providers only.** You must contact your financial institution to arrange for the delivery of the CCD+ Reassociation Data Elements with your EFT.

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	Delta Dental of Washington

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)	
☐ Provider Tax Identification Number (TIN)	
☐ National Provider Identifier (NPI)	

D. Submission Information		
*Reason for Submission		
☐ New Enrollment	☐ Change Enrollment	☐ Cancel Enrollment

Authorized Signature

Electronic or Printed Signature of Person Submitting Enrollment

Title of Person Submitting Enrollment

400 Vermillion St. Hastings MN 55033

DELTA DENTAL Delta Dental of Washington

Direct Deposit Authorization

Before completing this form, it's important to know:

- Multiple providers operating under one tax identification number (TIN) with the same payment address must share the same direct deposit bank account.
- You don't need to complete this authorization for new providers when there are already providers in your office who have the same TIN and payment address – and have enrolled in direct deposit already. They'll automatically be enrolled upon joining our networks. All claim payments for each provider will show on the same payment voucher.
- A copy of a voided check is required to process your direct deposit request.

PROVIDER INFORMATION

Provider Name (*Complete legal name of institution, corporate entity, practice or individual provider)*

Provider Address (*Payment*)

Street/PO Box | *City* | *State* | *Zip Code/Postal Code*

PROVIDER IDENTIFIERS

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

National Provider Identifier *(Type 2/Business NPI if applicable):*

PROVIDER CONTACT INFORMATION

Provider Contact Name:

Telephone Number: Fax Number:

Email Address:

NATIONAL EFT

National EFT is an option available to all our member dentists. It gives you the ability to be paid by EFT from other Delta Dental Plans Association Member Companies. If you choose to enroll, you authorize other Delta Dental Plans Association Member Companies to deposit funds for claim payments into the account listed below.

Would you like to enroll in National EFT? ☐ Yes ☐ No

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name:

Financial Institution Address:

Street | *City* | *State* | *Zip Code/Postal Code*

Financial Institution Telephone Number: Type of Account at Financial Institution: ☐ Checking ☐ Savings

Financial Institution Routing Number: Provider's Account Number with Financial Institution:

Account Number Linkage with Provider Identifier: *(select one)*

☐ Provider Tax Identification Number (TIN) ☐ National Provider Identifier (NPI) Type 2 (Business)

SUBMISSION INFORMATION

Reason for Submission:

☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Authorized Signature:

I hereby authorize Delta Dental of Washington, and any other Delta Dental Plans Association Member Company unless otherwise indicated above, to deposit funds for claim payments directly into the Financial Institution account listed above. This authority will remain in force and effective until I provide written notice to Delta Dental of Washington.

Submission Date: Requested EFT Start/Change/Cancel Date: *(must be future date)*

Submit this form through DocuSign, by **Fax**: (800) 460-3159, **email**: ProviderServices@DeltaDentalWA.com or mail to: Delta Dental of Washington, ATTN: Provider Services, PO Box 75688 Seattle, WA 98175