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DentaQuest

DENTAL ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT REGISTRATION

PAYER ID NUMBERS	CX014
ELECTRONIC REGISTRATIONS Agreements Required	Electronic Dental Services Provider Enrollment Form <ul style="list-style-type: none"> Please complete all requested information. Please advise EDS that you wish to receive ERAs from this payer.
SEND REGISTRATION FORMS TO	EDITeam@greatdentalplans.com
ENROLLMENT CONFIRMATION	EDS will automatically deliver the ERAs via the EDS Bridge or Portal.
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently receives ERAs through another Billing Agent other than EDS, each Provider must re-enroll following the procedures listed above.
LATE/MISSING EFT & ERA PROCEDURE	Pending Payer's Advice.
DISCONTINUING ERA	Discontinuing ERA is a 2 step process. <ol style="list-style-type: none"> Deactivation <ol style="list-style-type: none"> Providers receiving ERAs via their Practice Management Software need to request deactivation from their software Vendors. Please call your PMS directly. Providers receiving their ERAs via an EDS Portal account need only ignore the ERA option when logging into the EDS Portal. Payer Un-enrollment <ol style="list-style-type: none"> Each payer has their own unique process to discontinue ERAs and return to paper Remittance Advice. Please follow the below steps for this payer.
CONTACT PHONE NUMBERS	Electronic Dental Services 800-482-3518 option 5



DentaQuest Electronic Remittance Advice (ERA) Authorization Agreement.

Please be sure to complete all of the required fields (marked with a star) and email the completed form to EDITeam@greatdentalplans.com.

Please enter the following information:

Provider/Organization/Practice Identification:

Provider Name: * _____

Doing Business As Name (DBA): _____

Street: * _____

City: * _____

Zip Code: * _____

Country: * _____

State: * _____

Provider Identifiers:

Provider Federal Tax Identification Number (TIN): * _____

National Provider Identifier (NPI): * _____

Organization/Practice Contact Person:

Provider Contact Name: * _____

Telephone Number: * _____

Email Address: * _____

Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier)

Please choose aggregation type based on the identification used by your receiving bank on your bank account. If you are identified on your bank account by TIN, please choose TIN. If by NPI, please choose NPI. If you are identified by TIN, please do ***not*** choose NPI. The aggregation type must match your banking institution's identification on your bank account.

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

Method of Retrieval: *

Trading Partner Web Portal FTP Agent Direct Clearinghouse

Please enter information if you receive EDI transactions through a clearinghouse rather than directly.

Clearinghouse Name: * __EDS - Electronic Dental Services_____

Clearinghouse Contact Name: * __Enrollment_____

Telephone Number: * __800-482-3518 option 5_____

Email Address: * __enrollment@edsedi.com_____

Reason for Submission: * New Enrollment Change Enrollment Cancel Enrollment

Please type your name, date, and the requested effective ERA date for this enrollment below:

Written Signature of Person Submitting Enrollment: _____

Printed Name of Person Submitting Enrollment: _____

Submission Date: _____

Requested ERA Effective Date: _____

For assistance or questions regarding this form please contact our EDI Team at EDITeam@greatdentalplans.com and a representative will contact you. You may return this form via email at EDITeam@greatdentalplans.com .