

South Dakota Participating Providers DIRECT DEPOSIT ENROLLMENT FORM

**** New authorization – Complete Sections A, B, C & F**

****Changes to an existing authorization – Complete Sections A, B & D**

****Cancellation – Complete Sections A and E**

NOTE: The information disclosed below is confidential and will not be used other than for payment of dental services by Delta Dental of South Dakota

A. DENTIST INFORMATION (Please print or type-for Participating Dentists Only):

Dentist Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax number: _____

Name of Dental Office Contact Person: _____

Dentist's Social Security Number: _____ Tax ID number: _____

Dentist's License Number: _____ Individual Type I NPI _____
Business (Type II) NPI _____

Email Address: _____
(*Notified of check deposit via email)

How would you like to receive your Explanation of Benefits (EOB) (Circle One)?

Web Retrieval Report

Mail

B. BANKING/FINANCIAL INSTITUTION INFORMATION:

Name of Account Holder: _____

Institution's Name: _____

Bank Routing Number: _____ **Account Number:** _____

Branch (If Applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Type of Account: **Checking** **Savings**

See Back.....

C. AUTHORIZATION STATEMENT:

I authorize and request Delta Dental of South Dakota to send the net claim check directly into my bank account or other financial institution as specified in Section B of this form. I understand that Delta Dental of South Dakota has no authority to inquire about or withdraw funds from this account.

Dentist's Signature: _____ Date: _____

D. CHANGE AUTHORIZATION STATEMENT:

I authorize and request Delta Dental of South Dakota to make the changes indicated on this form. I will allow DDSD thirty (30) days from date of receipt of this document to accomplish these changes.

Dentist's Signature: _____ Date: _____

E. CANCELLATION STATEMENT:

I authorize and request Delta Dental of South Dakota to terminate authorized direct deposits to my account. I will allow DDSD thirty (30) days notice from receipt date of this document, to accomplish these changes. Unless otherwise noted, upon such cancellation (future) payments will be made to the participating dentist.

Dentist's Signature: _____ Date: _____

F. ATTACH A VOIDED CHECK MARKED "SAMPLE"

This is EXTREMELY important as your application cannot be processed without this information.

Retain a copy of this form for your records

Please return this form to:

**Delta Dental of South Dakota
PO Box 1157 • Pierre, SD 57501
Attention: Professional Relations**

If you have any questions or comments, please contact us at 800-627-3961