

Automatic Draft Authorization for Administrative Services Only Groups

DELTA DENTAL OF OKLAHOMA

Purpose of Authorization (select one)		
☐ New Authorization		
☐ Changes to existing authorization (<i>Note:</i> Changes will be completed within	in 30 days from date of receipt)	
Please print or type when completing this form.		
Name of Company:		
Group Number:		
Address:		
Phone Number:		
Name of Depositor:(Print name exactly as it appears on F	inancial Institution records)	
(Print name exactly as it appears on r	inancial institution records)	
Name of Financial Institution:	Branch:	
Address:		
Phone Number:		
Account Type:		
☐ Claims Reimbursement		
☐ Monthly Administrative Fee		
I (We) hereby authorize Delta Dental of Oklahoma (DDOK) and the financial ir reimbursements and/or administrative fees from the account I have indicate rejected draft.	_	
Authorized Group Contact (please print)	Title	Date
Signature*		Date
Note: A voided check must be attached to this authorization to process into	ended application.	
Drafts occur a minimum of two (2) days after the claims and/or administrative fee invoices are issued.		
*Signature must be that of an authorized signer on the account.		

Or mail this form with a voided check to: Delta Dental of Oklahoma

Email this form with a voided check to: Accounting@DeltaDentalOK.org

Attn: Finance P.O. Box 54709

Oklahoma City, OK 73154-1709

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