DELTA DENTAL®

ELECTRONIC FUNDS TRANSFER (EFT) ENROLLMENT FORM

Direct Deposit for Delta Dental of Oklahoma

Please check one.

☐ New Authorization: (complete sections **A**, **B**, **C**, and **F**)

☐ Changes to existing authorization: (complete sections **A**, **B**, **D** and **F**)

☐ Cancellation: (complete sections **A** and **E**)

Please return this form to the following address or fax number:

Delta Dental of Oklahoma
Provider Relations Department ***OR*** Fax: 405-607-2198
P.O. Box 54709
Oklahoma City, OK 73154-1709

After your office is enrolled in EFT, Claim Payment Statement (CPS) information can only be obtained online through PEARL, our Practice Electronic Administration Resource Link.

A. Dentist Information: (Please print or type)

Dentist Name: _____ and
Corporation Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone#: (_____) _____ Fax#: (_____) _____
Name of Contact Person: _____ Title _____
Dentist's Taxpayer Identification Number (TIN): _____
Dentist's State License Number: _____ Issuing State _____
Dentist's NPI # (Type 1) _____ (Type 2) _____

B. Banking/Financial Institution Information: (Please print or type)

Name of Account Holder: _____
Institution's Name: _____
Branch (If Applicable): _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____

Type of Account: ☐ Checking ☐ Savings (Please check one)

For Internal Use Only
Pearl Account: _____/_____

C. New Authorization Statement:

I authorize and request Delta Dental of Oklahoma to electronically send the net claim check directly into my bank account or other financial institution as specified in Section B of this form. I acknowledge that I must obtain my CPS online through PEARL. I understand I may terminate this agreement at any time by completing another EFT Enrollment form.

_____ _____

Dentist's Signature Date Signed

D. Change Authorization Statement:

I authorize and request Delta Dental of Oklahoma to make any changes indicated on this form. I will allow Delta Dental of Oklahoma thirty (30) days notice from receipt date to accomplish these changes.

_____ _____

Dentist's Signature Date Signed

E. Cancellation Statement:

I request Delta Dental of Oklahoma to terminate authorized direct deposits to my account. I will allow Delta Dental of Oklahoma thirty (30) days notice from receipt date to accomplish termination.

_____ _____

Dentist's Signature Date Signed

F. Check Information:

Please attach a voided check. This step is extremely important as your application cannot be processed without a voided check.

*The Provider Relations Department will be contacting your office to verify your EFT information has been received and to ensure you have a **PEARL** account.*

If you have any questions regarding the completion of this form, please contact the Provider Relations Department at 800-522-0188, ext. 137 (Toll Free) or 405-607-2137 (OKC Metro).

(Please retain a copy of this form for your records).