Moda Health/ODS / ODS Community Health Electronic Fund Transfer Enrollment Form

PROVIDER INFORMATION

Provider Name: ____________________

Doing Business As Name (DBA): ____________________

Provider Address:

Street ____________________

City ____________________

State/Province ____________________

ZIP Code/Postal Code ____________________

PROVIDER IDENTIFIERS INFORMATION

Provider Identifier

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

National Provider Identifier (NPI): ____________________

Other Identifier(s)

Provider Taxonomy Code: ____________________

PROVIDER CONTACT INFORMATION

Provider Contact Name: ____________________

Telephone Number: ____________________

Telephone Number extension: ________

Email Address: ____________________

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name: ______________________

Financial Institution Routing Number: ______________

Type of Account at Financial Institution: ______________

Provider's Account Number with Financial Institution: ______________

Account Number Linkage to Provider Identifier:

Provider Tax Identification Number (TIN): ______________

National Provider Identifier (NPI): ______________

SUBMISSION INFORMATION

Reason for Submission:

New Enrollment ________

Change Enrollment ________

Cancel Enrollment ________

Authorized Signature

Written Signature ______________________

Printed Name ______________________

Printed Title ______________________

Submission Date ______________

(ccyymmdd)

Confidential when completed. Please mail or fax form to:

Moda Health/ODS/ODS Community
ATTN: EDI Department
601 SW Second Ave
Portland, OR 97204
Fax #: 503-412-4068

NOTE: Do not send completed form via email.

Moda Health/ODS / ODS Community Health Electronic Remittance Advice (ERA) Enrollment Form

PROVIDER INFORMATION

Provider Name: ______________________

Doing Business As Name (DBA): ______________________

Provider Address:

Street ______________________

City ______________________

State/Province ______________________

ZIP Code/Postal Code ______________________

PROVIDER CONTACT INFORMATION

Provider Contact Name: ______________________

Telephone Number: ______________________

Telephone Number extension: __________

Email Address: ______________________

ELECTRONIC REMITTANCE ADVICE INFORMATION

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

Provider Federal Tax Identification Number (TIN): ______________________

National Provider Identifier (NPI): ______________________

Method of Retrieval: ______________________

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

Clearinghouse Name ______________________

SUBMISSION INFORMATION

Reason for Submission:

New Enrollment ______

Change Enrollment ______

Cancel Enrollment ______

Authorized Signature

Written Signature ______________________

Printed Name ______________________

Printed Title ______________________

Submission Date ______________________
(ccyymmdd)

Confidential when completed. Please mail or fax form to:
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Portland, OR 97204
Fax #: 503-412-4068
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Delta Dental National Electronic Funds Transfer Opportunity

To reduce the amount of EFT enrollment forms your office needs to complete, you now have the option to ask us to share your EFT information with other Delta Dental member companies nationwide (for when you see patients with employers headquartered in other states). Delta Dental member companies outside of OR/AK will begin using the EFT information that is shared nationally by the end of 2016.

Please mark your preference below so we can handle as requested:

_____ Yes, please share my enrollment information nationally.

_____ No, use the information provided only for Delta Dental of OR and AK.

Dentist/Office Name ______________________________

Authorizing Signature ______________________________ Title ________________________

☐ I have read the Terms and Conditions (required)

Terms and conditions

In consideration for the provision of direct deposit services, by signing above, and notwithstanding any language to the contrary herein, you hereby acknowledge and agree that (i) any information you have provided, including but not limited to, the information you supplied under the heading "Banking Information" , may be transferred, shared or otherwise provided by us to or with any entity that is an affiliate of Delta Dental, as defined above, with other Delta Dental member companies and their affiliates, and with Delta Dental Plans Association, for use in connection with funds to be deposited to your account, (ii) allow at least 3 weeks to process any election to discontinue enrollment in this direct deposit program, it may not be effective to halt any deposits that were initiated while your enrollment in this direct deposit program was in effect, and (iii) in the absence of gross negligence or willful misconduct, neither we, any of our members and affiliates, other Delta Dental member companies and their affiliates, or Delta Dental Plans Association, will be responsible for any damages, or for any fee, charge or other expense assessed against the Bank Account identified , in connection with this direct deposit program.

Further, by accepting these terms, you represent and warrant that (i) all of the information you supplied is true and accurate, (ii) the information provided under the heading "Banking Information," identifies a bank account held by the Business you identified, and (iii) the signatory to this Direct Deposit Enrollment Form ("Form") has all necessary power and authority to execute this Form.