



**Delta Dental of Virginia
Direct Deposit Enrollment Form**

Purpose of Authorization {Purpose for completing this form}

*New Authorization: (complete section A, B, C, D, and G)

*Changes to an existing authorization (complete sections A, B, C, and E)

*Cancellation: (complete sections A and F)

Please return this form to the following address

Delta Dental of Virginia
4818 Starkey Rd
Roanoke, VA 24018
Or you may fax to 540-774-7797

Participating Dentists only

A. Dentist Information (Please Print or Type)

Dentist Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Name of Office Contact: _____

Provider's Social Security Number: _____

Tax Identification Number: _____

Providers License Number _____ Issuing State: _____

E-Mail Address: _____

Providers NPI _____ Practice NPI _____

B. Banking / Financial Institution Information: (Please Print or Type)

Name of Account Holder: _____

Institution's Name: _____

Branch (If Applicable): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Type of Account (Circle One) Checking Savings



C. Automatic Deposit:

____ I submit Claims electronically through a clearinghouse or the internet.

____ I do not submit Claims electronically.

D. New Authorization:

I authorize and request Delta Dental of Virginia (hereinafter called DDVA) to send the net claims check directly to my bank or other financial institution as specified in Section B of this form. I understand I may terminate this agreement at any time by completing another "Direct Deposit Authorization" or in any event by sending a thirty (30) day written notice to terminate (with new request/instructions for future payment)

Dentist Signature

Date Signed

E. Change Authorization Statement:

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

Dentist Signature

Date Signed

F. Cancellation Statement:

I authorize and request DDVA to terminate authorized direct deposits to my account. I will allow DDVA 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 Signature

Date Signed

G: Attach a voided check marked SAMPLE. This step is EXTREMELY important as your application cannot be processed without a voided check.

If you have any questions or comments regarding the completion of this form, please contact Delta Dental of Virginia at 1-800-367-3531.