1304 Vermillion Street • Hastings, MN 55033
Ph 800-482-3518 • Fax 651-389-9152
www.edsedi.com

DELTA DENTAL OF WISCONSIN
DENTAL ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT REGISTRATION

PAYER ID NUMBERS	**39069**
SPECIAL NOTES	**Participation with Electronic Fund Transfer (EFT) is required for receipt of Electronic Remittance Advice (ERA).** **When dental offices register with Delta Dental of Wisconsin for EFT, the mailing of paper documents stop immediately. At that point, the dental office receives electronic notice each time their payment documents are posted on the secure website - www.deltadentalwi.com under the Dentist Connection. The online Explanation of Payment documents duplicate the paper document format. Dental offices will always have current and historical access to the Explanation of Payment documents online.**
ELECTRONIC REGISTRATIONS **Agreements Required**	**Electronic Dental Services Provider Enrollment Form** • Please complete all requested information. **Electronic Transfer of Funds (EFT)/Direct Deposit** • Please complete all requested information • Please attach a voided check or preprinted deposit slip as required in section B.
Dual Delivery of v5010 X12 835 and Proprietary Paper Claim Remittance Advices ☐	As part of the Affordable Care Act (effective 1-1-14), health plans are required to dual deliver the electronic (ERA/835) and paper remittance advices for a minimum of 31 calendar days or at least 3 payment cycles. At the conclusion of this time period, delivery of the paper remittance advices may be discontinued. Providers who wish to continue receiving paper remittance advices for a longer period of time may request so by contacting the health plan directly. Upon mutual agreement between the provider and the health plan, the timeframe for delivery of the paper remittance advices may be extended by an agreed-to timeframe. If the provider determines it is unable to satisfactorily implement and process the health plan's electronic v5010 X12 835 following the end of the initial dual delivery timeframe and/or after an agreed-to extension, both the provider and health plan may mutually agree to continue delivery of the proprietary paper claim remittance advices.
CCD+ Reassociation	As part of the ERA enrollment process, and to comply with the Affordable Care Act CAQH CORE Rule #370, EDS requests you contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements. **CCD+ Record # / Field # / Field Name** 5 / 9 / Effective Entry Date 6 / 6 / Amount 7 / 3 / Payment Related Information The data contained in the Minimum CCD+ data elements will allow you to easily associate your EFT and ERA transactions. You may read more about the CAQH CORE Rule 370 at the CAQH website http://caqh.org/
SEND REGISTRATION TO	EDS 1304 Vermillion Street Hastings, MN 55033 Attn: Provider Enrollment Or Email to: enrollment@edsedi.com Or Fax to: 651-389-9152

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ENROLLMENT CONFIRMATION	ERA enrollments take approximately 5-10 business days for completion. Once complete, EDS will notify the provider or their PMS vendor, as defined by the PMS vendor.
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently receives ERAs through another Billing Agent other than EDS, each Provider must re-enroll following the procedures listed above.
LATE/MISSING EFT & ERA PROCEDURE	Pending payer's advice.
DISCONTINUING ERA	Discontinuing ERA is a 2 step process. 1. Deactivation a. Providers receiving ERAs via their Practice Management Software need to request deactivation from their software Vendors. Please call your PMS directly. b. Providers receiving their ERAs via an EDS Portal account need only ignore the ERA option when logging into the EDS Portal. 2. Payer Un-enrollment a. Each payer has their own unique process to discontinue ERAs and return to paper Remittance Advice. Please follow the below steps for this payer. If a provider wishes to discontinue receiving ERAs from Delta Dental Wisconsin email request to pr@deltadentalwi.com or call Provider Relations at 800-836-0490.
CONTACT PHONE NUMBERS	Delta Dental WI Provider Relations 800-836-0490 Electronic Dental Services 800-482-3518

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Insurance Carrier:_____ - ERA Payer ID(s)_____

*Provider Name: _____
(Complete legal name of institution, corporate entity, practice or individual provider)

Doing Business as Name (DBA):_____

Provider Address:_____
*(Street)

_____ _____ _____ _____
* (City) * (State/Province) * (ZIP Code/Postal Code) (Country Code)

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

*National Provider Identifier (NPI):_____

*Provider Contact Name: _____ Title: _____

*Telephone Number: _____ Telephone Number Extension: _____

*Email Address: _____ Fax Number: _____

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

☐ Provider Tax Identification Number (TIN) ☐ National Provider Identifier (NPI)

Method of Retrieval: Clearinghouse

Clearinghouse Name: EDS

Vendor Name: _____

*Reason for Submission: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

*Authorized Signature: _____
(The signature of an individual authorized by the provider or its agent to initiate, modify or ternate and enrollment. May be used with electronic and paper-based manual enrollment)

Printed Name of Person Submitting Enrollment: _____

Printed Title of Person Submitting Enrollment: _____

Submission Date: _____

Requested ERA Effective Date: _____

* Required

Delta Dental of Wisconsin:
Electronic Remittance Advice (ERA)/835
Authorization Agreement – Instructions and Enrollment Form

Special Notes	**Participation in Dental Electronic Remittance Advice (ERA)/835 is limited to those providers whose practice management software vendor is participating in ERA with one of the clearinghouses listed on page 2.** **Please contact your practice management software vendor for more details.** **Participation in ERA is further limited to those providers who participate in Electronic Funds Transfer (EFT)/Direct Deposit. If you are not yet an EFT participant, please also complete the EFT enrollment form on page 3.**
Where to submit your completed enrollment form	**Please contact your practice management software vendor for information on how and where to submit your enrollment form.**
Delta Dental of Wisconsin contact information	**Delta Dental of Wisconsin** **Professional Services Department** **PO Box 828** **Stevens Point, WI 54481** **800-836-0490** **Fax 715-343-7611** **pr@deltadentalwi.com**
Enrollment Confirmation	**Once enrollment processes are complete, Delta Dental of Wisconsin will notify the provider via email or fax to confirm the ERA start date.**
Late or missing ERA or EFT	**If your expected ERA or EFT appears to be late or missing, please contact Delta Dental of Wisconsin's Professional Services Department at 800-836-0490 or pr@deltadentalwi.com.**

Delta Dental of Wisconsin Administrative Use Only:

_____ _____ _____ OR _____ _____ _____

Dentist License Number | State | Office Location Number | Clinic Number | DDWI Representative Initials | date

Electronic Remittance Advice (ERA)/835 Enrollment Form

PROVIDER INFORMATION

Provider Name

_____

Provider Address

_____

(Street) (City) (State) (ZIP Code)

PROVIDER IDENTIFIERS INFORMATION

Provider Identifiers

_____

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

_____ _____

National Provider Identifier (Individual Provider - NPI1) National Provider Identifier (Organizational Provider - NPI2)

PROVIDER CONTACT INFORMATION

Provider Contact Name

_____

_____ _____

Telephone Number Email Address

ELECTRONIC REMITTANCE ADVICE INFORMATION

Preference for Aggregation of Remittance Data: Remittance Data is aggregated by Provider Tax Identification Number (TIN).

ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

Clearinghouse Name

(check one) ☐ emdeon®

VOID

ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION

Vendor Name

(Please provide the name of your practice management software vendor.) _____ _____

SUBMISSION INFORMATION

Reason for Submission

(check one) ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Authorized Signature (The signature of an individual authorized by the provider or its agent to initiate, modify, or terminate an enrolllment)
This authority is to remain in full force and effective until Delta Dental of Wisconsin Inc. receives written notification from me/us of its termination in such time and manner as to afford DDWI reasonable opportunity to act on it.

_____

Written Signature of Person Submitting Enrollment

_____

Printed Name of Person Submitting Enrollment

Submission Date **Requested ERA Effective Date**

_____ _____

Participation in ERA is limited to those providers who participate in Electronic Funds Transfer (EFT)/Direct Deposit with Delta Dental of Wisconsin.

- If you are currently enrolled in EFT with Delta Dental of Wisconsin, please check the statement below.

☐ **I am currently enrolled in EFT with Delta Dental of Wisconsin.**

- If you are NOT currently enrolled in EFT with Delta Dental of Wisconsin, you must complete the Electronic Funds Transfer (EFT)/Direct Deposit Enrollment form below to be eligible for ERA.

Electronic Funds Transfer (EFT) / Direct Deposit Enrollment Form

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

_____

Financial Institution Telephone Number

_____

Financial Institution Routing Number

_____

Type of Account at Financial Institution: ☐ **Checking** ☐ **Savings**

Provider's Account Number with Financial Institution

_____

Account Number Linkage to Provider Identifier

_____

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

SUBMISSION INFORMATION

Reason for Submission

(check one) ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Include with Enrollment Submission (check one)

☐ Voided Check ☐ Bank Letter (A letter on bank letterhead that formally certifies the account owners routing and account numbers)

Authorized Signature (The signature of an individual authorized by the provider or its agent to initiate, modify, or terminate an enrolllment)
This authority is to remain in full force and effective until Delta Dental of Wisconsin Inc. receives written notification from me/us of its termination in such time and manner as to afford DDWI reasonable opportunity to act on it.

_____

Written Signature of Person Submitting Enrollment

_____

Printed Name of Person Submitting Enrollment

Submission Date _____ **Requested EFT Start/Change/Cancel Date** _____

EXPLANATION OF PAYMENT (EOP) DELIVERY OPTIONS

Select Delivery Option (choose one):

☐ E-mail notification with delivery of Explanation of Payment to Delta Dental's website

_____

E-mail to receive direct deposit notification

☐ Fax delivery of Explanation of Payment

_____

Fax Number to receive EOP