

**Dental Fully Insured Groups  
Automated Clearinghouse Authorization Agreement**

**Company Name** \_\_\_\_\_

authorizes the charge to our bank account through the Automated Clearinghouse (ACH) for the ***Total Amount Due*** according to our Invoice / Statement. Premium will be taken on the first business day of each month.

**Group Number** \_\_\_\_\_

**ACH Effective Date** \_\_\_\_\_

**Bank Name** \_\_\_\_\_

**Bank Address** \_\_\_\_\_

**Bank Account Number** \_\_\_\_\_

**Type of Account** ☐ Checking ☐ Savings

**Bank Account Name** \_\_\_\_\_

**Bank Routing Number** \_\_\_\_\_

(between these symbols  on the bottom left of your check)

**PLEASE INCLUDE A VOIDED CHECK**

**Authorized Individual of  
the Account**

Print \_\_\_\_\_

Signature \_\_\_\_\_

Today's Date \_\_\_\_\_

Title \_\_\_\_\_

Telephone Number \_\_\_\_\_

E-Mail address \_\_\_\_\_

**Questions? Please call our Billing and A/R Department at: 1-877-606-3409**

**Please complete this form and fax to us at: 1-877-803-2433**

**or,**

**Please complete this form and mail to:**

**Anthem  
ATTN: Dental Billing and A/R  
PO Box 1171  
Minneapolis, MN 55440-1171**

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