Anthem
Health. Join In.

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