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Ph 800-482-3518 • Fax 651-389-9152
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DELTA DENTAL OF IOWA
DENTAL ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT REGISTRATION

PAYER ID NUMBERS	**CDIA1**
SPECIAL NOTES	**• Providers must be in state and participating with Delta Dental of Iowa.** **• Electronic Fund Transfer (EFT) is required for receipt of Electronic Remittance Advice (ERA).**
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	Electronic Dental Services 1304 Vermillion St. Hastings, MN 55033 e-mail to: enrollment@edsedi.com Fax to: 651-389-9152
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.

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	If a provider wishes to discontinue receiving ERAs from Delta Dental Iowa, email a request to provrelations@deltadentalia.com or call Provider Relations at 800-544-0718.
CONTACT PHONE NUMBERS	Delta Dental IA Provider Relations 800-544-0718 Electronic Dental Services 800-482-3518

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Insurance Carrier: Delta Dental Iowa - ERA Payer ID(s) CDIA1

*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

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DENTAL ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT REGISTRATION DEFINITIONS

Table: 4.2-1 CORE-required Maximum ERA Enrollment Data Set

Individual Data Element Name (Term)	Sub-element Name (Term)	Data Element Description	Data Type and Format (Not all data elements require a format specification)	Data Element Requirement for Health Plan Collection (Required/ Optional for plan to collect)	Data Element Group Number (DEG#)
PROVIDER INFORMATION (Data Element Group 1 is a Required DEG)					
Provider Name		Complete legal name of institution, corporate entity, practice or individual provider	Alphanumeric	Required	DEG1
Doing Business As Name (DBA)		A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it.	Alphanumeric	Optional	DEG1
Provider Address				Optional	DEG1
	Street	The number and street name where a person or organization can be found	Alphanumeric	Required	DEG1
	City	City associated with provider address field	Alphanumeric	Required	DEG1
	State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.	Alpha	Required	DEG1
	ZIP Code/Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities	Alphanumeric, 15 characters	Required	DEG1
	Country Code	ISO-3166-1 Country Code	Alphanumeric, 2 characters	Optional	DEG1
PROVIDER IDENTIFIERS INFORMATION (Data Element Group 2 is a Required DEG)					
Provider Identifiers				Required	DEG2
	Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity	Numeric, 9 digits	Required	DEG2
	National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions	Numeric, 10 digits	Required when provider has been enumerated with an NPI	DEG2
PROVIDER CONTACT INFORMATION (Data Element Group 3 is an Optional DEG)					
Provider Contact Name	Contact	Name of a contact in provider office for handling ERA issues		Required	DEG3
	Title			Optional	DEG3
	Telephone Number	Associated with contact person	Numeric, 10 digits	Required	DEG3
	Telephone Number Extension			Optional	DEG3
	Email Address	An electronic mail address at which the health plan might contact the provider		Required; not all providers may have an email address	DEG3
	Fax Number	A number at which the provider can be sent facsimiles		Optional	DEG3

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ELECTRONIC REMITTANCE ADVICE INFORMATION (Data Element Group 7 is a Required DEG)					
Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)		Provider preference for grouping (bulking) claim payment remittance advice – must match preference for EFT payment		Required; select from below	DEG7
	Provider Tax Identification Number (TIN)		Numeric, 9 digits	Optional – required if NPI is not applicable	DEG7
	National Provider Identifier (NPI)		Numeric, 10 digits	Optional – required if TIN is not applicable	DEG7
Method of Retrieval		The method in which the provider will receive the ERA from the health plan (e.g., download from health plan website, clearinghouse, etc.)		Optional (Required if the provider is not using an intermediary clearinghouse or vendor)	DEG7
ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION (Data Element Group 8 is an Optional DEG)					
Clearinghouse Name		Official name of the provider's clearinghouse		Required	DEG8
ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION (Data Element Group 9 is an Optional DEG)					
Vendor Name		Official name of the provider's vendor		Required	DEG9
SUBMISSION INFORMATION (Data Element Group 10 is a Required DEG)					
Reason for Submission				Required; select from below	DEG10
	New Enrollment			Optional	DEG10
	Change Enrollment			Optional	DEG10
	Cancel Enrollment			Optional	DEG10
Authorized Signature		The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment		Required; select from below	DEG10
	Electronic Signature of Person Submitting Enrollment			Optional	DEG10
	Written Signature of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity		Optional	DEG10
	Printed Name of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment		Optional	DEG10
	Printed Title of Person Submitting Enrollment	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment		Optional	DEG10
Submission Date		The date on which the enrollment is submitted	CCYYMMDD	Optional	DEG10
Requested ERA Effective Date		Date the provider wishes to begin ERA; per Phase III CORE Health Care Claim Payment/Advice (835) Infrastructure Rule Version 3.0.0: there may be a dual delivery period depending on whether the entity has such an agreement with its trading partner	CCYYMMDD	Optional	DEG10

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Delta Dental of Iowa 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 - NPI 1) National Provider Identifier (Organizational - NPI 2)

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®**

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 enrollment)
This authority is to remain in full force and effective until Delta Dental of Iowa (DDIA) receives written notification from me/us of its termination in such time and manner as to afford DDIA reasonable opportunity to act on it.

_____
Written Signature of Person Submitting Enrollment and Title

_____
Printed Name of Person Submitting Enrollment

Submission Date: _____

Requested ERA Start/Change/Cancel Date: _____

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

- If you are currently enrolled in Direct Deposit/EFT with Delta Dental of Iowa, please check the statement below.
  ☐ **I am currently enrolled in Direct Deposit/EFT with Delta Dental of Iowa.**

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

❖ ❖

Delta Dental of Iowa Direct Deposit / Electronic Funds Transfer (EFT) 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)

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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 enrollment)
This authority is to remain in full force and effective until Delta Dental of Iowa (DDIA) receives written notification from me/us of its termination in such time and manner as to afford DDIA reasonable opportunity to act on it. In addition, I (we) certify to the best of my (our) knowledge that the banking information given is not that of a foreign banking institution (located outside of the United States).*

Please sign, date and return completed form, along with voided check or bank letter to: Professional Relations, Delta Dental of Iowa, 9000 Northpark Dr., Johnston, IA 50131 or Fax to 515-261-5608

_____
Written Signature of Person Submitting Enrollment and Title

_____
Printed Name of Person Submitting Enrollment

Submission Date: _____

Requested Direct Deposit Start/Change/Cancel Date: _____

*If you banking institution is a foreign bank, please contact Delta Dental of Iowa at 800-544-0718 for further instructions.

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 Explanation of Payment

Delta Dental of Iowa Administrative Use Only:

_____ _____ _____
Date DDIA Representative Initials Clinic Number