Federal Government Programs Dentist/Dental Office

Authorization for Direct Deposit

DELTA DENTAL®

INSTRUCTIONS

Please complete sections **A, B** and **C** and return this Authorization for Direct Deposit to the following address:

Delta Dental of California
Federal Government Programs
PO Box to 537007
Sacramento, CA 95853- 7007

SECTION A – BUSINESS INFORMATION (PLEASE TYPE OR PRINT)

Authorized Account Holder's Name: ____________________

Business Name: ____________________

Business Address: ____________________

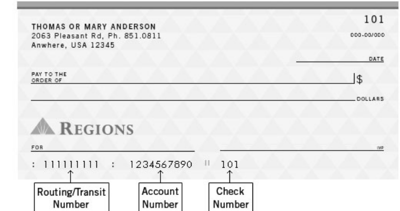
City: ____________________ State: ________ ZIP Code: ____________________

Business Tax Number (number used for IRS reporting): ____________________

Phone: (_____)____________________ Fax: (_____)____________________ Email: ____________________

SECTION B – BANK/FINANCIAL INSTITUTION INFORMATION

Note: *Please confirm with your banking institution that your account can accept ACH deposits and that you have provided the correct ABA for ACH transactions.*



Name of Financial Institution: ____________________

Name on Bank Account: ____________________

☐ Checking ☐ Savings

Transit Rounting (ABA) Number (always 9 digits): ☐☐☐☐☐☐☐☐☐

Bank Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

SECTION C – AUTHORIZATION STATEMENT

By signing below, I request and authorize Delta Dental of California, in accordance with my Participation Agreement, Uniform Requirements and applicable Delta Dental policies and procedures, to deposit funds for claim payments directly into the account with the bank/financial institution as specified in Section B, and agree to the following:

1. The effective date for direct deposit will be fifteen (15) days from the date Delta Dental receives the completed and signed Authorization for Direct Deposit.
2. All account changes instituted by the bank/financial institution listed in section B require fifteen (15) days prior written notice sent to Delta Dental at the address listed above. Upon receipt of said written notice, Delta Dental will consider it an amendment to this Authorization for Direct Deposit.
3. Termination of this authorization requires fifteen (15) days written notice along with the effective date of termination and the reason for termination (i.e., account closed; account changed), sent to Delta Dental at the address listed above.
4. All account changes instituted by the Business Name listed in Section A require (15) days prior written notice accompanied by a new signed Authorization for Direct Deposit sent to Delta Dental at the address listed above.
5. Delta Dental may terminate this Authorization for Direct Deposit at any time without cause.

____________________ Signature of Authorized Account Holder

____________________ Date Signed

RETAIN A COPY OF THIS COMPLETED AUTHORIZATION FOR DIRECT DEPOSIT FOR YOUR RECORDS

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