

**DentaQuest Electronic Remittance Advice (ERA) Authorization Agreement.**

Please be sure to complete all of the required fields (marked with a star) and email the completed form to [EDITeam@greatdentalplans.com](mailto:EDITeam@greatdentalplans.com) .

Please enter the following information:

**Provider/Organization/Practice Identification:**

Provider Name:\* \_\_\_\_\_

Doing Business As Name (DBA): \_\_\_\_\_

Street: \* \_\_\_\_\_

City: \* \_\_\_\_\_

Zip Code: \* \_\_\_\_\_

Country: \* \_\_\_\_\_

State: \* \_\_\_\_\_

**Provider Identifiers:**

Provider Federal Tax Identification Number (TIN):\* \_\_\_\_\_

National Provider Identifier (NPI): \* \_\_\_\_\_

**Organization/Practice Contact Person:**

Provider Contact Name: \* \_\_\_\_\_

Telephone Number: \* \_\_\_\_\_

Email Address: \* \_\_\_\_\_

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

Please choose aggregation type based on the identification used by your receiving bank on your bank account. If you are identified on your bank account by TIN, please choose TIN. If by NPI, please choose NPI. If you are identified by TIN, please do **\*not\*** choose NPI. The aggregation type must match your banking institution's identification on your bank account.

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

Method of Retrieval: \*

Trading Partner Web Portal    FTP    Agent    Direct    Clearinghouse

**Please enter information if you receive EDI transactions through a clearinghouse rather than directly.**

Clearinghouse Name: \* \_\_\_\_\_

Clearinghouse Contact Name: \* \_\_\_\_\_

Telephone Number: \* \_\_\_\_\_

Email Address: \* \_\_\_\_\_

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

**Please type your name, date, and the requested effective ERA date for this enrollment below:**

Written Signature of Person Submitting Enrollment: \_\_\_\_\_

Printed Name of Person Submitting Enrollment: \_\_\_\_\_

Submission Date: \_\_\_\_\_

Requested ERA Effective Date: \_\_\_\_\_

For assistance or questions regarding this form please contact our EDI Team at [EDITeam@greatdentalplans.com](mailto:EDITeam@greatdentalplans.com) and a representative will contact you. You may return this form via email at [EDITeam@greatdentalplans.com](mailto:EDITeam@greatdentalplans.com) .