Electronic Remittance Advice &
Electronic Fund Transfer Enrollment Form

Please check the appropriate boxes:

☐ EFT (includes all dental product payments) ☐ ERA - Dental Maintenance Organization® Monthly Compensation

☐ ERA (All other Dental Product payments)

☐ Enroll ☐ Change ☐ Cancel

NOTE: ERA is currently only offered through ClaimConnect. If you are selecting ERA and not currently enrolled in ClaimConnect or are enrolled in ClaimConnect but have not yet requested ERA, please contact Dentalxchange at 800-624-2904 prior to submitting this enrollment form to Aetna.

Please provide your ClaimConnect User ID: _____

Please complete the following information:

***Practice Information*:**

Name: _____Tax Identification Number (TIN):_____

Contact Name: _____ E-Mail Address: _____

National Provider Identification (NPI): _____

Phone Number ( ) _____ Fax Number ( ) _____

Addresses:
Primary Service:

_____

_____

Primary Billing:

_____

_____

Practice Management Vendor: _____ Vendor Phone Number ( ): _____

Vendor Contact Name: _____ Vendor E-mail Address: _____

Do you require EFT and ERAs to be split by billing location? ☐ Yes ☐ No

Please complete the following bank account information for EFT:

To take advantage of direct deposit (EFT), your bank must be a participating member of the Automated Clearinghouse Association (ACH). Please note if you require payments to be deposited into multiple bank accounts, bank account information must be completed for each account. New EFT enrollment or changes to existing EFT banking information will trigger a new EFT pre-note period. The EFT pre-note period will run for 10 days from the effective date. Production will start on day 11. You are responsible for notifying Aetna if your banking information should change.

Bank Name _____ Address _____
Bank ID (first 8 digits of the routing number) __ __ __ __ __ __ __ __
Bank SCD (self-checking digit / the last digit of the routing number) __
Account Number _____ Account Type Savings ☐ or Checking ☐
Please include a copy of your cancelled check or Savings Account Deposit Ticket

Please complete for each additional bank account

Bank Name _____ Address _____
Bank ID (first 8 digits of the routing number) __ __ __ __ __ __ __ __
Bank SCD (self-checking digit / the last digit of the routing number) __
Account Number _____ Account Type Savings ☐ or Checking ☐
Please include a copy of your cancelled check or Savings Account Deposit Ticket

Authorization Agreement for Direct Deposit of Benefits Payments. Please read and sign your name below.

I hereby authorize Aetna, on behalf of itself and its affiliates, including Aetna Life Insurance Company and Aetna Health Inc. (hereinafter "Company") to initiate credit entries to the account(s) at the bank(s) listed above for all benefits payments. This agreement will remain in effect until I notify Company of the desire to cancel or change this service or until Company notifies me that this service has been terminated. I understand that I must allow reasonable time for my instructions to be executed. If Company credits more money than the correct benefit amount to the account due to duplicate electronic funds transfers (where "duplicate" is defined as multiple electronic funds transfers received for the same services rendered, the same membership, and the same dates of service) or erroneous electronic funds transfers (where erroneous is defined as complete electronic funds transfers received in error), I authorize Company to withdraw the overpayment. I authorize and request the bank listed above to accept any credit entries by Aetna to such account and to credit the same to such account.

Electronic Remittance Advice (ERA) – Pended Claims

When state requirements require information that cannot be accommodated in our HIPAA compliant ERA transaction such as information regarding pended claims, health care professionals can obtain this information in other ways:
- For pended claims received **electronically,** the request for information is returned in a Claim Status Response (277). However, Aetna is aware that some providers have agreements with their vendor/clearinghouse to receive some, all or none of their unsolicited claim status responses. Therefore, please work with your vendor/clearinghouse to ensure that you receive all level 2 claim status responses in order to receive this information. If you prefer, or are unable to receive these responses, you may utilize the real- time claims status inquiry transaction to obtain this information as well.
- For pended claims received on **paper,** a request for more information may be sent by letter or phone call. However if you have not received any such request within 30 days of a claim submission on paper, please utilize the claim status inquiry transaction to view this information.

For more information on utilizing claim status inquiry transaction, refer to www.aetnadental.com.

Thank you for your cooperation in this effort.

By signing below, I hereby agree that I have read and agree to the terms and conditions stated above including Authorization for Direct Deposit of Benefits Payments, Legislative Updates and Pended Claims.

Please Print Name _____ ***Date***_____

Dental Professional Authorized Signature _____ ***Date***_____

Form Completed by: _____
Phone Number ( ): _____ **Fax Number ( ):** _____
E-mail Address: _____

Please fax completed form to:

Aetna Dental at 1-904-351-5997

Aetna Dental - PO Box 44020 - Jacksonville, FL 32232-4020