



Dental Electronic Funds Transfer (EFT) Authorization Agreement

We'd like you to enroll in Electronic Funds Transfer (EFT). EFT is a free and secure way for you to receive your payments faster. You'll no longer have to wait for checks to arrive in the mail. Aetna can issue EFT's to all healthcare provider types, including those receiving capitation. And, EFT doesn't change our overpayment policies and procedures. If you are overpaid, we'll send you a letter asking for a refund by check.

Use the following guide when completing your ERA/EFT enrollment forms. Fields with an asterisk are **required**; **sections left blank or illegible will delay processing**. If you want to change your banking information, please complete the ERA/EFT enrollment form at: <https://www.aetnadental.com/i/E/ERAEFTErollmentForm.pdf>

- Please send only one tax ID per fax. Enrollments for additional tax ID numbers must be faxed separately. If you would like us to deposit EFT claim payments into multiple bank accounts for the same TIN, complete a separate form for each account.
- Include your payee NPI (NPI receiving payment) on the enrollment form. **Note:** If the provider is part of a group, it is not necessary to enroll the Payee NPI/TIN combination more than once. All providers will be included in the 835 remittance file if claims are submitted to Aetna using the Payee NPI/TIN combination listed. Please list **two or more NPIs** under the 'Preference for Aggregation of Remittance Data' or for 'Account Number Linkage' for EFT. Selecting NPI as aggregation method will create ERA/EFT for ONLY the NPI(s) specified on the enrollment form.
- Include a copy of a pre-printed voided check with the account holder name imprinted on the check or bank letter. Deposit slips, starter checks, handwritten or altered checks are not accepted. **We cannot process your enrollment without this information.**
- Once we transmit an EFT to your bank, your bank has 3 business days to settle the funds and make them available in your account. Claims already in process on or before your effective date will still generate paper checks.
- With your enrollment in EFT, unless you have submitted an ERA request for an approved vendor, your paper EOBs will be discontinued within **31** days. EOBs can be retrieved or viewed through the EOB Tool on www.aetnadental.com.
- ERA effective date may not be retroactive. Future date only.
- If you are requesting EFT for your capitated payments, you must be set up for capitation. You only need to complete one form if the bank account is the same for both Dental and Capitation claim payments. Capitation payments made under a single TIN can only be deposited into one bank account.
- The enrollment form **must** be signed by authorized healthcare individuals. The signing authority must match the legal entity associated with the tax ID.
Practitioner (MD, DO, DC, DDS, PhD, etc.)
Corporate Officer or Authorized Manager (CEO, CFO, Office Manager, etc.)
- You must contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation of the EFT payment with the ERA remittance advice.
- To check the status of an EFT enrollment or change request, call **National Dentist Line 800-451-7715**

IMPORTANT:

Please allow 30 business days for processing. Processing times may vary depending on number of enrollments received, the accuracy of the information provided and whether the form is legible. We will send confirmation letting you know when ERA and/or EFT will start. To take advantage of direct deposit (EFT), your bank must be a participating member of the Automated Clearinghouse Association (ACH). You are responsible for notifying Aetna of any changes to your banking information. You may receive a phone call from Aetna to ensure accuracy of banking information.

- For **new enrollments** complete the EFT authorization agreement in its entirety and fax to **859-455-8650**.
- For **EFT changes** and **ERA/EFT terminations (cancel)**, complete all applicable sections of the ERA and EFT authorization agreement and fax to **859-455-8650**.
- You may also mail your completed form to **Aetna Dental – PO Box 14094 – Lexington, KY 40512-4094**.



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Please fax only one TIN per form. A separate form for each TIN must be used

Asterisk indicates required fields within each section. Incomplete and/or illegible fields and signatures will cause your enrollment to be delayed. Refer to instructions before completing this form.

| | | | | | | | | | | |
|---|--|--|----------------|----------------|----------------|---|----------------------|----------------------|--|--|
| PROVIDER INFORMATION | | | | | | | | | | |
| *Provider Name | | | | | | | | | | |
| *Provider Address | | | | | | | | | | |
| Street | | | | | | | | | | |
| City | | | | | State/Province | | | ZIP Code/Postal Code | | |
| PROVIDER IDENTIFIERS INFORMATION | | | | | | | | | | |
| *Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) | | | | | | | | | | |
| *National Provider Identification Number (NPI) | | | | | | | | | | |
| Other Identifier(s): | | | | | | | | | | |
| Assigning Authority _____ Trading Partner ID _____ | | | | | | | | | | |
| PROVIDER CONTACT INFORMATION | | | | | | | | | | |
| *Provider Contact Name | | | | | | | | Title | | |
| *Telephone Number () - | | | *Email Address | | | | | Fax Number () - | | |
| FINANCIAL INSTITUTION INFORMATION – Refer to instructions if you are enrolling more than one bank account | | | | | | | | | | |
| *Financial Institution Name | | | | | | Financial Institution Address | | | | |
| | | | | | | Street | | | | |
| City | | | | State/Province | | | ZIP Code/Postal Code | | | |
| *Financial Institution Routing Number | | | | | | *Type of Account at Financial Institution | | | | |
| | | | | | | <input type="checkbox"/> Checking <input type="checkbox"/> Saving | | | | |
| *Provider's Account Number with Financial Institution | | | | | | | | | | |
| | | | | | | | | | | |
| *Account Number Linkage to Provider Identifier (Select One) | | | | | | | | | | |
| <input type="checkbox"/> Provider Tax Identification Number (TIN) _____ | | | | | | | | | | |
| <input type="checkbox"/> National Provider Identification Number (NPI) _____ | | | | | | | | | | |
| SUBMISSION INFORMATION (Check One) | | | | | | | | | | |
| *Reason for Submission: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change Enrollment <input type="checkbox"/> Cancel Enrollment | | | | | | | | | | |
| *Include with Enrollment Submission <input type="checkbox"/> Bank Letter <input type="checkbox"/> Voided Check | | | | | | | | | | |

Authorization Agreement – Please read and sign your name below.

Electronic Funds Transfers (EFT)

I hereby authorize Aetna, on behalf of itself and its affiliates, including Aetna Life Insurance Company, Aetna Health Inc., Innovation Health Holdings, LLC, Coventry Health Care, Inc. ("Company") and their respective subsidiaries, to initiate credit entries to the account at the bank 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 I must allow reasonable time for my instructions to be executed. 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.

Company will not debit or deduct funds directly from my bank account for claim overpayments and/or refund requests, but Company will seek permission to debit my bank account for any adjustments or corrections to resolve duplicate payments (where "duplicate" is defined as Company sending multiple identical payments in error) or erroneous payments due to a bank account setup error. Company will attempt to recover the duplicate or erroneous payment via a debit to my account to the extent permitted by state law and with prior contact to me. If an electronic debit is unsuccessful, Company will notify me in writing reach an alternative arrangement for reimbursement.*

* Company strictly adheres to the National Automated Clearing House Association (NACHA) guidelines.

Electronic Remittance Advice (ERA) – Legislative Updates

Certain claims payment/remittance information required by various state requirements cannot be transmitted using the HIPAA-compliant ERA transaction. Aetna retains a list of state requirements that cannot be accommodated in our HIPAA-compliant ERA transactions. In the event you need confirmation or clarification of Legislative Updates, please contact our National Provider Number. Thank you for your cooperation in this effort.

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 claims status responses. Therefore, please work with your vendor/clearinghouse to ensure you receive all level 2 claims status responses in order to receive this information. If you prefer, or are unable to receive these responses, you may use 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 **31** days of a claims submission on paper, please use the claims status inquiry transaction to view this information.

Please work with your Aetna representative if you need assistance using the claims status inquiry transaction. Thank you for your cooperation in this effort.

AUTHORIZED SIGNATURE

By signing below, I hereby agree that I have read and agree to the terms and conditions stated above, including Legislative Updates and Pended Claims. Furthermore, the undersigned certifies that the information provided is true and accurate in all respects and that he/she has been duly authorized by all necessary and appropriate action.

The form must be signed by authorized healthcare individuals.

*Written Signature of Person Submitting Enrollment _____
*Printed Name of Person Submitting Enrollment _____
*Printed Title of Person Submitting Enrollment _____
Submission Date _____

If you prefer not to aggregate by TIN or NPI and are not enrolling the entire Tax ID, please select an alternative setup:

Split by Billing Address – Enroll only certain **Billing Locations** under the Tax ID for EFT payments.

List the applicable Billing Locations to enroll for EFT payment. _____

Electronic Explanation of Benefits (EOBs)

As a registered user of Aetna's secure provider website via www.aetnadental.com, you can access your EOBs online via the claim EOB tool. Your electronic EOB is immediately available once a claim is processed. This allows you to post payments several days sooner than if you used a paper EOB. Not registered? Please click here to register: www.aetnadental.com

Your paper EOBs will stop **31** days after the effective date of the EFT set up.

Yes, please turn off paper EOBs immediately following EFT set-up.

Submit only one form per FAX. Faxes containing multiple forms will be returned.

Fax the completed form, voided check and/or bank letter to:

- **859-455-8650** for new EFT enrollments.
 - To check the status of an ERA enrollment, call **800-451-7715**
- **859-455-8650** for EFT changes and ERA/EFT termination requests.
 - To check the status of an EFT change, call **800-451-7715**

Definitions
Electronic Funds Transfer (EFT)

| PROVIDER INFORMATION | |
|--|--|
| Provider Name | Complete legal name of institution, corporate entity, practice or individual provider |
| (Provider Address) Street | The number and street name where a person or organization can be found |
| City | City associated with provider address field |
| State/Province | ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country |
| 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 |
| PROVIDER IDENTIFIERS INFORMATION | |
| Provider Identifiers | Enter TIN and NPI information |
| 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 |
| 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 dental specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions |
| (Other Identifiers) Assigning Authority | Organization that issues and assigns the additional identifier requested on the form, e.g., Medicare, Medicaid |
| Trading Partner ID | The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor. Enter User Name/App ID/Customer ID/Key/Acct Number (if applicable) |
| PROVIDER CONTACT INFORMATION | |
| Provider Contact Name | Name of a contact in provider office for handling ERA issues |
| Title | Title of contact |
| Telephone Number | Associated with contact person |
| Email Address | An electronic mail address at which the health plan might contact the provider |
| Fax Number | A number at which the provider can be sent facsimiles |
| FINANCIAL INSTITUTION INFORMATION | |
| Financial Institution Name | Official name of the provider's financial institution |
| Financial Institution Street Address | Street address associated with receiving depository financial institution name field |
| City | City associated with receiving depository financial institution address field |
| State/Province | ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country |
| 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 |
| Financial Institution Routing Number | A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited |
| Type of Account at Financial Institution | The type of account the provider will use to receive EFT payments, e.g., Checking, Saving |
| Provider's Account Number with Financial Institution | Provider's account number at the financial institution to which EFT payments are to be deposited |
| Account Number Linkage to Provider Identifier | Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice. Select from TIN or NPI. Numeric, 9 digits |
| SUBMISSION INFORMATION | |
| Reason for Submission | Select your reason for submission from the options available. |
| Include with Enrollment Submission | Voided check: A voided check is attached to provide confirmation of Identification/Account Numbers 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. May be used with electronic and paper-based manual enrollment |
| 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 |
| 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 |
| 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 |
| Submission Date | The date on which the enrollment is submitted |