

## ERA/EFT DMC Customer Enrollment Agreement

The current monthly fee for Electronic Remittance Advice and Electronic Funds Transfer is **\$24.95**. This fee includes one office location up to three providers in that location. (Please use an additional sheet of paper for more than two providers)

The dental office must complete all enrollment requirements requested by each insurance company. Please call DAISY if you have questions. 503.765.3471 or 800.368.6401

This Enrollment Agreement must be returned to DMC completed and signed **before** the doctor will receive ERA/EFT transactions.

### PROVIDER INFORMATION

Provider Name: \_\_\_\_\_ Type 1 NPI \_\_\_\_\_

Provider Name: \_\_\_\_\_ Type 1 NPI \_\_\_\_\_

Facility Name: \_\_\_\_\_ Type 2 NPI \_\_\_\_\_

Facility Address: \_\_\_\_\_

Billing Address: \_\_\_\_\_

(If different than the Facility Address)

City, State, Zip Code: \_\_\_\_\_

Tax ID \_\_\_\_\_

Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ (Required)

Authorized Signature: \_\_\_\_\_  
(Must be the name on the DMC contract or the representative authorized to sign for the account)

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

By signing, I confirm that the above information is correct. This authority is to remain in full force and effect until DMC has received written notification from me of its termination with a 30 day notice.

DMC reserves the right to change the pricing with a 30 day notice.

### Please Mail or Fax completed form to:

Dentists Management Corporation

Attn: **Operations Dept.**

10505 SE 17<sup>th</sup> Avenue

Milwaukie, OR 97222

Fax: 503.765.3451

Please check Payers you are using:

<input type="checkbox"/>	<b>ODS</b>
<input type="checkbox"/>	<b>Regence of OR</b>
<input type="checkbox"/>	<b>Emdeon (Aetna, Cigna, etc.)</b>
<input type="checkbox"/>	<b>Deltas of MI, IN, OH</b>