DELTA DENTAL

Electronic Funds Transfer (EFT) Authorization: Direct Billing Members

Member Information		
First Name	Last Name	
Group Name		Member ID
Address		
City	State	Zip Code
Phone	Email	

Bank Information		
Name of Financial Institution		Phone
City	State	Zip Code
Authorized Account Holder Name		
Bank Routing Number		
Account Number		
Account Type ☐ Checking ☐ Savings		

Delta Dental of Arizona will keep all financial information secure and confidential

Authorization

I (we) hereby authorize Arizona Dental Insurance Service Inc., dba Delta Dental of Arizona, to initiate debit (withdrawal) entries and to initiate, if necessary, credit entries and adjustments for any debit (withdrawal) entries in error to my account and the financial institution indicated above.

This authorization is to remain in full force and effect until Delta Dental of Arizona and said financial institution have received written notification from me of its termination in such time and in such manner to afford Delta Dental of Arizona and said financial institution a reasonable opportunity to act upon it.

I understand that any EFT transactions that are dishonored by my financial institution may be assessed a $25 service charge.

_____ Signature of Account Holder

_____/_____/_____ Date

Submission
Please email, fax or mail the completed EFT authorization to:

Delta Dental of Arizona
14850 N. Scottsdale Rd.
Scottsdale, Suite 400, AZ 85254
Email: billing@deltadentalaz.com
Fax: 602.548.5071