DELTA DENTAL®

Delta Dental of Illinois
Billing and Banking Information Form

Group Number _____

Group Name _____

Billing Contact _____

Eligibility Contact _____

Group Administrator _____

Funding Mechanism:

☐ Self-Funded Dental

☐ Fully-Insured Dental

☐ DeltaCare

Payment Frequency:

☐ Weekly (Self-Funded Dental Only)

☐ Monthly

Payment Method if Monthly (All Products):

☐ Wire Transfer

☐ Check

Prefund Amount: _____

Date Collected: _____

If Fully Insured and group has multiple locations, does group require summary billing?

☐ Yes ☐ No

Payment Method if Weekly (Dental Only):

☐ ACH Debit

☐ Wire Transfer

☐ E-Mail ☐ Fax

Note: If group opts to pay weekly, admin fees will be added to the last funds transfer of the month.

If ACH Debit please supply Banking Information:

Bank Name _____

Account Number _____

Routing Number _____

Weekly report recipient(s):

_____

_____

Monthly Billing Delivery Method (All Products):

☐ E-Mail/Online Billing

☐ Fax

☐ Other:

Special Billing Requirements:

Designated Super User for Online Dental Billing: _____

Designated Super User for Online Dental Eligibility: _____

Group Administrator Signature: _____ Date: _____