

### Direct Deposit Facts and Authorization

Washington Dental Service offers the option of receiving claim payments electronically, using direct deposit. With this service, you can have your WDS claim payments deposited directly to your bank account. What will this mean to you?

- **Faster payment on your claims**
- **Streamlined office administration**
- **No checks to track and deposit**
- **Your money is available immediately**

There is no cost on your part to receive payment through direct deposit – all you need is a fax machine.

Deposits will be made each week you have claim payments, and the payment voucher will be faxed to you the same day. If you are a General Practitioner who participates in the DeltaCare network, your monthly Patient Roster and Encounter payments will also be deposited directly into your account and notification of these payments will be sent via email. You will receive your Patient Roster via a secured email.

To enroll in the Washington Dental Service automatic direct deposit program, simply complete this form and return it – and a blank/voided check if you are using a checking account – to Washington Dental Service.

If you have any questions or would like additional information, please call Provider Services at (206) 528-7394 or (800) 238-3439.

#### AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT BY WASHINGTON DENTAL SERVICE

ALL WDS PAYMENTS  DELTACARE PAYMENTS ONLY

Dentist Name: \_\_\_\_\_ Physical address: \_\_\_\_\_

License : \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Dental Office E-mail address: \_\_\_\_\_ *(required if you are a DeltaCare Primary Care provider)*

**I hereby authorize Washington Dental Service to make deposits into my bank account as indicated below:**

Account Name: \_\_\_\_\_  
(business name listed on the account)

Bank Name: \_\_\_\_\_ Bank Phone #: \_\_\_\_\_

Bank address: \_\_\_\_\_

Type of account:  **Checking account, please attach a blank/voided check** *(a deposit slip is not acceptable)*

**Savings account** *(Please verify with your bank the following information)*

ABA#: \_\_\_\_\_ Account #: \_\_\_\_\_

**Money market account** *(please verify with your bank whether this is classified as a savings or checking account and indicate below)*

*Savings*       *Checking*

ABA#: \_\_\_\_\_ Account #: \_\_\_\_\_

This authorization will remain in full force and effect until I provide written notice to Washington Dental Service.

Dr. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Fax completed agreement and check copy directly to our dept at: 1-800-460-3159.

**OR**

Mail directly to our dept at:  
Washington Dental Service  
Attn: Provider Services  
PO BOX 75688  
Seattle WA 98175