DENCAP
dental plans Est. 1984

EFT AUTHORIZATION

- I understand I must notify DENCAP immediately and complete a new authorization form if I change financial institutions, account numbers or type of account.
- DENCAP is not responsible for fees incurred due to invalid banking information, or changes not submitted in time to stop the deposit
- This agreement will remain in effect until DENCAP Dental Plans, Inc. receives a written notice of cancellation from me or my financial institution, or until I submit a new authorization from to DENCAP.

Please note: The email provided will be utilized for your Provider File Share. This email address will receive notifications for all documents uploaded by DENCAP to your File Share account. These documents include the monthly Capitation Payment Detail and monthly Member Eligibility Listing which contain the information needed for EFT (bank deposit) reconciliation.

Dental Office Information	
Office Name:	**DENCAP Office ID #: ___ ___ ___**
EFT Information	
Bank Name:	
Routing Number:	
Account Number:	
Email:	
Authorized Signature:	**Date:**
DENCAP OFFICE USE ONLY	
Date Received: ____________ Date Processed: ___________ Initials: _____________________	
☐ **EFT set up** ☐ **File share set up**	

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