



DENCAP Dental Plans - Provider 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 #: _____
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EFT Information

Bank Name:	
Routing Number: _____	
Account Number:	
Email:	
Authorized Signature:	Date:

DENCAP OFFICE USE ONLY

Date Received: _____	Date Processed: _____	Initials: _____
<input type="checkbox"/> EFT Set Up	<input type="checkbox"/> File Share Set Up	

Submit Via:

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