Payer ID: Per the payer list

Delta Dental

Includes all payers listed below

835

EDI Enrollment Instructions:

- Please save this document to your computer. Open the file in the Adobe Reader program and type directly onto the form.
- **Providers must be currently submitting 837 transactions prior to enrolling for the 835 Electronic Remittance Advice. Please do not submit 835 enrollment until after claim submission has begun.**
- Complete the form using the **provider's billing/group information as credentialed** with this payer.
- Once completed, save, print and obtain appropriate signature.
- EDI enrollment processing timeframe is approximately **10 business days**.

837 Claim Transactions:

Enrollment applies to ERA only and is not necessary prior to sending claims.

835 Electronic Remittance Advice:

Delta Dental Electronic Remittance Advice (ERA) Enrollment Form

Complete all applicable fields.

Submit Completed Document:

Email to Tesia

registrations@tesiasupport.com

Dental Payers Included

Delta Dental of Alabama	Delta Dental of New Mexico
Delta Dental of Arkansas	Delta Dental of New York
Delta Dental of California	Delta Dental of North Carolina
Delta Dental of Florida	Delta Dental of Ohio
Delta Dental of Georgia	Delta Dental of Pennsylvania
Delta Dental of Indiana	Delta Dental of Tennessee
Delta Dental of Kentucky	Delta Dental of Texas
Delta Dental of Louisiana	Delta Dental of Utah
Delta Dental of Maryland	DeltaCare USA
Delta Dental of Michigan	Dentegra
Delta Dental of Mississippi	Renaissance Life and Health
Delta Dental of Montana	Tricare Retiree Dental
Delta Dental of Nevada	

Tesia Clearinghouse
1540 West Edgewood Avenue
Indianapolis, IN 46217
Phone: (866)712-9584

Electronic Remittance Advice Enrollment – Delta Dental Plans

PROVIDER INFORMATION

*Provider Name: _____
(Complete legal name of institution, corporate entity, practice, or individual provider.)

Doing Business as Name (DBA): _____

Provider Address: _____
*Street (The number and street name where a person or organization can be found.)

_____ _____ _____ _____
*City *State/Province *Zip Code/Postal Code Country Code

*Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):

_____

*National Provider Identifier (NPI): _____

**License Number: _____ **License Issuer (State): _____
**License Number and Issuer are required for Delta Dental of Washington ERA enrollment only

*Contact Name: _____ Title: _____

*Telephone Number: _____ Telephone Number Extension: _____

*Email Address: _____ Fax Number: _____

ERA INFORMATION

*Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)
(Provider preference for grouping (bulking) claim payment remittance advice – MUST match preference for EFT Payment)

◯ Provider Tax Identification Number (TIN)

◯ National Provider Identifier (NPI)

Method of Retrieval: Clearinghouse

Clearinghouse Name: Tesia Clearinghouse

Vendor Name: eSolutions, Inc.

SUBMISSION INFORMATION

*Reason for Submission: ◯ New Enrollment ◯ Change Enrollment ◯ Cancel Enrollment

*Authorized Signature: _____
Written Signature of Person Submitting Enrollment

_____
Printed Name of Person Submitting Enrollment

_____
Printed Title of Person Submitting Enrollment

Submission Date: _____

Requested ERA Effective Date: _____