



## Electronic Remittance Advice (ERA) Setup Form / Secure EDI

Please complete the information below and send to Delta Dental of Minnesota

Fax: [877-283-1330] / Address: Attn: Professional Services PO Box 9304 Minneapolis, MN 55440-9304

<b>Remittance Request for:</b> <input type="checkbox"/> Delta Dental of MN <input type="checkbox"/> Delta Dental of NE	Note: By registering for ERA, you will no longer receive paper EOBs.
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All fields are required

Provider / Practice Information	
Name (of person requesting ERA)	
Title	
Provider/Practice Name	
Address	
City, State, Zip	
Phone Number	
e-mail	
Contact Name	
Tax ID	
Trading Partner ID	<input type="checkbox"/> Apex EDI <input type="checkbox"/> Availity <input type="checkbox"/> Community Dental Care <input type="checkbox"/> Dental XChange/EHG <input type="checkbox"/> Kings Computer Mgmt <input type="checkbox"/> Lindsay Tech Service <input type="checkbox"/> Prof Business Service <input type="checkbox"/> QSI <input type="checkbox"/> SecureEDI <input type="checkbox"/> U of MN <input type="checkbox"/> Other (please list)

### Authorization

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date