Anthem Health. Join In.

Dental Fully Insured Groups
Automated Clearinghouse Authorization Agreement

Company Name ______________________________

authorizes the charge to our bank account through the Automated Clearinghouse (ACH) for the ***Total Amount Due*** according to our Invoice / Statement. Premium will be taken on the first business day of each month.

Group Number ______________________________

ACH Effective Date ______________________________

Bank Name ______________________________

Bank Address ______________________________

Bank Account Number ______________________________

Type of Account ❑ Checking ❑ Savings

Bank Account Name ______________________________

Bank Routing Number ______________________________

(between these symbols on the bottom left of your check)

PLEASE INCLUDE A VOIDED CHECK

Authorized Individual of the Account

____
Print

____
Signature | Today's Date

____
Title | Telephone Number

____
E-Mail address

Questions? Please call our Billing and A/R Department at: 1-877-606-3409
Please complete this form and fax to us at: 1-877-803-2433
or,
Please complete this form and mail to:

Anthem
ATTN: Dental Billing and A/R
PO Box 1171
Minneapolis, MN 55440-1171

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