Superior Dental Care®

800.762.3159 | superiordental.com |

Auto Deposit Authorization

Participating Dentist Name: _____

Tax ID Number *(A separate form is needed for each TIN)*: _____

Office Location: _____

We hereby authorize SUPERIOR DENTAL CARE, INC. to initiate credit entries to our account indicated below at the financial institution named below.

Name on the Account: _____

Account Number: _____

Type of Account (circle one): CHECKING SAVINGS

Financial Institution Name: _____

Address: _____

Routing and Transit Number: _____

***IMPORTANT:** Please attach a copy of a voided check or letter of account verification from your financial institution to ensure proper processing.*

This authorization will remain in full force and effect until SUPERIOR DENTAL CARE, INC. has received written notification from the Participating Dentist of intent to terminate this service in such time and in such manner as to afford SUPERIOR DENTAL CARE, INC. and BANK to act upon it.

Name of Authorized Person: _____

Signature: _____

Date: _____ Fax Number: _____

Email Address: _____

This email address will be used to notify you of a deposit and provide the associated Claim Voucher Statement.

Please return completed form by mail or fax:

Superior Dental Care
Attn: Dentist Services
6683 Centerville Business Parkway
Centerville, OH 45459

FAX (866) 788-7301