



Direct Deposit Authorization Form

PLEASE SIGN AND FAX, MAIL OR EMAIL TO:

MCNA Dental Plans
200 W Cypress Creek Rd., Suite 500
Ft. Lauderdale, FL 33309
Fax (954) 397-7441 : swallen@mcna.net

Complete this form for EFT payments ONLY. If you prefer to receive your payments via regular US Mail do not complete this entire form. Check the applicable box to the right; sign & print your name, date the form and return it along with your application and documents.

EFT: YES NO

Paper EOB: YES NO

PAYEE NAME:	TAX IDENTIFICATION NUMBER:
Address:	

PAYEE E-MAIL ADDRESS FOR EOB NOTIFICATION:	PAYEE PHONE NUMBER:	CONTACT'S FULL NAME & NUMBER:
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BANK NAME:	NAME ON ACCT:	ROUTING NUMBER:	ACCOUNT NUMBER:
Address:			
Phone:			

PLEASE ATTACH A VOIDED CHECK HERE.

(Required)

MCNA will EFT (direct deposit) your payments **DIRECTLY** into your bank account. We will also send you an email confirmation of your EFT transaction as well as your EOB to the email address you have provided above.
If you have questions, please call Credentialing at (877) 375-6262 extension 103.

I hereby give authorization to MCNA to credit the account at the named financial institution above for the sole purpose of transferring payments from MCNA to my account. MCNA is also granted authorization to correct funds erroneously deposited and other necessary debit/credit entries. I understand that my deposit may take up to 2 business days to post to my account. This authorization is to remain in effect until notification is given to MCNA in writing (requires a minimum of 10 business days notice) on another MCNA Direct Deposit Authorization Form advising of any change in the information on this form. I understand that the processing of changes may take up to 10 days to take effect. My signature below attests to the correctness of the information on this form and my acknowledgement of change requirements.

AUTHORIZED SIGNATURE:	PRINT YOUR NAME & TITLE:	TODAY'S DATE:
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