

## DENTAL PREFERRED PROVIDER NOMINATION REQUEST

Please complete the information requested below to nominate a dentist or dental specialist who is not listed in our Provider Directory. When we receive your nomination, it will be reviewed for appropriate action. Thank you.

**DENTIST'S NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
Street

\_\_\_\_\_  
City State Zip Code

**COUNTY:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_

**SPECIALTY:** \_\_\_\_\_

**MEMBER'S NAME:** \_\_\_\_\_

**GROUP NAME/GROUP NUMBER:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
Street

\_\_\_\_\_  
City State Zip Code

**TELEPHONE NUMBER:** \_\_\_\_\_

May we use your name when contacting this dentist? \_\_\_\_\_

**MAIL TO:**

Provider Relations Department  
Healthplex, Inc.  
333 Earle Ovington Blvd., Suite 300  
Uniondale, NY 11553-3608

**FAX:**

(516) 228-9571