Provider Nomination Form

Employer Group Name: ____________

Group/Plan Number: _______________

____
Patient Name

____
Plan Member (if different from patient)

____
Address

____
City State Zip

____
Area Code Telephone

My name may be used when contacting my dentist.

Yes _____ No _____

____
Date

____
Dentist Name

____
Dental Specialty

____
Dentist Address

____
City State Zip

____
Area Code Telephone

____
Provider Network Name (e.g. 100) if known

E-Mail nomination form to:

providernomination@anthem.com

Or

Fax form to:

Attn: Recruitment Center

Fax # 877-803-2418