Provider Nomination Form

Employer Group Name: ***NYDCC*** Group/Plan Number: L08248

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

XPO Dental Complete

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

E-Mail nomination form to:

providernomination@anthem.com