

# Dentist Nomination Form

## Coventry Health Care Dental Program

I would like to nominate my dentist for consideration by the DentalGuard® Preferred Select Network. I understand my name may be used when contacting my dentist to inform him/her of this nomination:

Nomination Date: DD  MM  YY

Patient's First Name:

Patient's Last Name:

Patient's Address:

City State Zip

Health Plan: MAILHANDLERSBENEFITPLAN

### To be completed by Dentist's Office:

Yes. I would like information on joining the DentalGuard® Preferred Select Network.

Dentist First Name:

Dentist Last Name:

Date of Birth: DD  MM  YY

Address:

City State Zip

Phone: --

Specialty: ,,,

Tax ID: (required)

Dentist's Signature: (required) \_\_\_\_\_

Please submit completed form to:

Coventry Health Care  
Special Negotiations/Provider Networks  
750 Riverpoint Drive  
West Sacramento, CA 95605

If you have any questions, feel free to call The Guardian at 1-800-890-4774.