HEALTHPLEX
THE DENTAL BENEFIT EXPERTS℠

MEMBER
Provider Nomination Form

I would like to recommend the provider named below for participation in my dental plan.

Provider Information

Provider's Name

☐ General Provider ☐ Specialist Provider *(Name Specialty)*

Address

City State Zip

County Phone #

Additional Information:

Member Information

Date of Request

Requested by *(Member/Group Name)*

Address

City State Zip

Phone # Social Security # or ID Number

May we use your name when contacting provider?

Note: This does not guarantee a provider's participation. Thank you for your interest in expanding our provider panel.

Please mail, fax or email this completed form to:

Provider Relations Department
Healthplex, Inc.
333 Earle Ovington Boulevard, Suite 300
Uniondale, NY 11553-3608
F 516 228 9571
E providerrelations@healthplex.com