

Provider Nomination Form

Employer Group Name:

Teamsters Joint Council No. 83 of VA
Health & Welfare Fund

Group/Plan Number:

004000004

Patient Name

Date

Plan Member (if different from patient)

Dentist Name

Address

Dental Specialty

City State Zip

Dentist Address

Area Code Telephone

City State Zip

My name may be used when contacting my dentist.

Area Code Telephone

Yes _____ No _____

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