

# Provider Nomination Form

Employer Group Name: \_\_\_\_\_

Group/Plan Number: \_\_\_\_\_

\_\_\_\_\_  
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](mailto:providernomination@anthem.com)

**Or**

Fax form to:

**Attn: Recruitment Center**

**Fax # 877-803-2418**