

NY State Dental Plan Provider Nomination Form

Today's Date _____

Patient Name _____

Address _____

City _____ State _____ Zip _____

Phone Number (____) _____

My name may be used when contacting my dentist?

Yes No

Dentist Name _____

Dentist Address _____

City _____ State _____ Zip _____

Dentist Phone Number (____) _____

Email Nomination Form to:

providernomination@anthem.com

