DELTA DENTAL

DENTIST NOMINATION FORM

YES! I would like you to contact my dentist
about becoming a participating Delta Dental dentist.

Please print legibly.

Name: _____

You may or may not use my name (*please circle one*).

Employer Group Name/Number: _____

Dentist Name: _____

Dental Practice Name: _____

Address: _____

_____

Phone Number: _____

Dentist Name: _____

Dental Practice Name: _____

Address: _____

_____

Phone Number: _____

Please return the completed form to the Provider Relations Department.

- **Fax:** 973-285-4192 *or*
- **Email:** ddsrelations@deltadentalnj.com

If you have any questions, or would prefer to call in your dentist nomination, please call **Customer Service**: 800-452-9310.

www.deltadentalnj.com