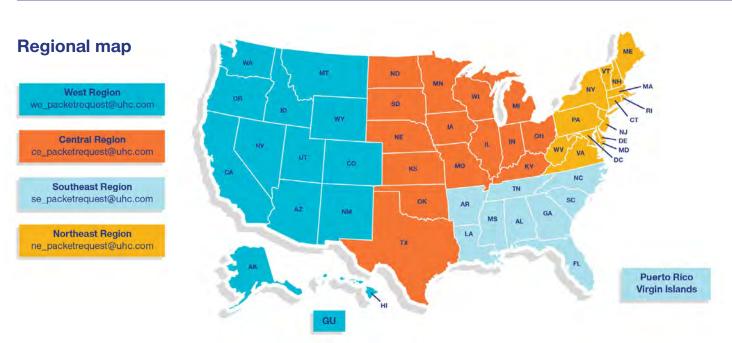
Provider packet request form

Please complete all fields and email the completed form to the email address* that applies to your state and region. (Refer to the **Regional map** below as your guide.)

Please indicate in the email subject line - Packet Request [State] [County].

Dentist first name:	Dentist last name:	Associate/owner:	NPI:	Specialty:
Please check the dental network(s) that you wish to join:				
PPO (Commercial) Medicare Medicaid			DHMO/Direct Compensation	
Email:			Contact name:	
Practice name:			Phone number:	
Address:			County:	
City:			State:	ZIP code:
Mailing address: (if different from practice address)				
City:			State:	ZIP code:
Are the dentists above being added to an existing participating location? Yes No				
Is this a new practice location? Yes No				



^{*}Important Note: Only requests to join our network are processed through the email addresses above. If your request does not relate to a provider joining our network or a packet request, please reach out to us at 800-822-5353 for further assistance.