

# DENTIST NOMINATION FORM

(This is not an enrollment form)



**SafeGuard**

I would like to nominate my dentist for the SafeGuard provider network.

**Date:** \_\_\_\_\_

**Employer or Group Name:** \_\_\_\_\_

**Employee's Name:** \_\_\_\_\_

**Patient's Name (if different from Employee's name):** \_\_\_\_\_

**Relationship to Employee (i.e. spouse, child, self, etc.):** \_\_\_\_\_

**City:** \_\_\_\_\_ **County:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work:** \_\_\_\_\_

**Name of plan in which Member is enrolling:** \_\_\_\_\_

**Effective Date of Plan (mm-dd-year):** \_\_\_\_\_

## DENTIST INFORMATION

**Office Name:** \_\_\_\_\_

**Office Manager:** \_\_\_\_\_

**Doctor's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Suite:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**County:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Specialty:** \_\_\_\_\_

Please submit completed form to:

SafeGuard Health Plans, Inc.

P.O. Box 18406

Tampa, FL 33679-8406

Or Fax to: 813-229-2323