

## *Dentist Nomination Form*

**Dentist Name:** \_\_\_\_\_

**Practice Name:** \_\_\_\_\_

**Dentist Address:** \_\_\_\_\_

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

**County:** \_\_\_\_\_ **Dentist Phone Number:** \_\_\_\_\_

**Mbrs Name:** \_\_\_\_\_

**Mbrs Phone Number:** \_\_\_\_\_

**Please check your plan type:**  **Dental HMO**

**Dental PPO**

**Government Programs**

### **FOR CALIFORNIA PROVIDER NOMINATIONS**

Please fax the completed form to **714-513-6490**, Attn: **Network Recruitment** or send via e-mail to [kimberly\\_p\\_sheldrake@optumhealth.com](mailto:kimberly_p_sheldrake@optumhealth.com)

### **FOR ALL OTHER PROVIDER NOMINATIONS**

Please fax the completed form to **877-572-3043**, Attn: **Network Recruitment** or e-mail it to us at [networkrecruit@uhc.com](mailto:networkrecruit@uhc.com).

**All MN providers should contact Premier Dental Group Leased Vendor at 1-800-392-3112.**