healthplex

MEMBER
Provider Nomination Form

I would like to recommend the provider named below for participation in my dental plan.

PROVIDER INFORMATION

Provider's Name

☐ General Provider ☐ Specialist Provider *(Name Specialty)*

Address

City State Zip

County Phone #

Additional Information

MEMBER INFORMATION

Date of Request

Requested by *(Member/Group Name)*

Address

City State Zip

Phone # Social Security or ID #

May we use your name when contacting provider?

Note: *This does not guarantee a provider's participation. Thank you for your interest in expanding our provider panel.*

Please mail, fax or email this completed form to:

Provider Relations Department
Healthplex, Inc.
PO Box 211672
Eagan, MN 55121
P 888.468.2183
F 516.228.5027
E providerrelations@healthplex.com

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