UnitedHealthcare®

Dentist Nomination Form

If you would like to nominate a dentist and/or dental office to join our network, please complete the following information.

Dentist Name: _____

Practice Name: _____

Dentist Address: _____

City: _____ **State:** _____ **Zip:** _____

Dentist Phone Number: _____

Your Name: (optional) _____

Your Phone Number: _____

Please fax the completed form to **240-632-8187, Attn: Network Recruitment** or e-mail it to us at **networkrecruit@dbp.com**.

One of our Dental Recruiters will contact the dental office to see if they would like to join our network of participating providers. Please allow 4-6 weeks for recruitment efforts to be completed.

Thank you for your nomination.