

## DentalGuard Preferred Dentist Nomination Form

I would like to nominate my dentist for inclusion in the DentalGuard Preferred Provider Network. I understand that the Guardian retains final authority for approving membership in the provider network. I also understand that the Guardian may use my name when contacting my dentist and inform him/her of my desire for them to join the network.

**NOTE: This form does not serve as an enrollment form for dental insurance or to register with the dental office as a patient.**

DATE: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Phone: \_\_\_\_\_

### **DENTIST**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

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

Please submit completed form to:

Guardian  
DentalGuard Preferred  
P.O. Box 981574  
El Paso, TX 79998-1574



or FAX to: 509-468-6550

