PREMIER ACCESS
Medical • Dental • Vision

Preferred Provider Nomination Form

I would like to nominate my dentist for inclusion in the Premier Access Preferred Provider network. I understand that the Premier Access retains final authority for approving membership in the provider network. I also understand that Premier Access 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: _____

Telephone: _____

Dentist: _____

Name: _____

Address: _____

_____

_____

Telephone: _____

Specialty: _____

If you have any questions about participating in Premier Access' provider network, please do not hesitate to contact us at: 800.640.4466

Please submit form to: Premier Access
Network Operations
P.O. Box 659010
Sacramento, CA. 95865-9010

Or FAX to: 916-646-9000