



Total Dental Administrators Dental Provider Nomination Form

I would like to nominate my dentist for inclusion in the Total Dental Administrators Network. I understand that Total Dental Administrators retains final authority for approving membership in the provider network. I also understand that TDA 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.

Date: _____

Patient's Name: _____

Employer: _____

Telephone: _____

DENTIST INFORMATION

Name: _____

Address: _____

Telephone: _____

Specialty: _____

If you have any questions about participating in the Total Dental Administrators Provider Network, please contact us at: (602) 266-1995.

Please submit form to: Total Dental Administrators, Inc.
Attn: Provider Relations Dept.
969 E. Murray Holladay Road, Suite 4E
Salt Lake City, UT 84117
Or fax to: (801) 268-9873

For more information about Total Dental Administrators, please visit our website at
www.totaldentaladmin.com