Advantage Dental Plan®
The Advantage Community

PROVIDER NOMINATION FORM
ADVANTAGE DENTAL/PACIFICSOURCE NETWORK

PLEASE RETURN TO
FAX (541) 504-3907
442 SW UMATILLA AVE, STE 200
REDMOND, OR 97756-9928

SECTION I: TO BE COMPLETED BY THE MEMBER

If your dental care provider is not currently in the Advantage Dental Network, you can use this form to nominate him or her for participation. First, complete the section below. Then send the form on to your provider, or drop it off at your next visit.

If your dental provider is interested in joining the network, he or she should complete the form and return it to Advantage. We will then follow up directly with your provider.

Patient name: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Employer: _____

Insurance carrier: **PacificSource Health Plans**

SECTION II: TO BE COMPLETED BY THE HEALTHCARE PROVIDER

You have obviously worked hard to foster solid relationships with your patients—relationships built on trust and respect. As a result, you are being asked by the patient named above to become part of the Advantage Dental/PacificSource Network.

By participating in this Network, you will be listed on the Advantage Dental and PacificSource websites promoting your practice.

- As a group of more than 1200 dentists, Advantage Dental has agreements with dental supply companies, and other business service providers to help save your practice money on services you use everyday.
- The Advantage Community lobbies the state legislature to ensure that dentistry is preserved.
- PacificSource/Advantage insurance products are designed to be dentist friendly and encourage patients to use contracted prviders.

You can find out more or apply online by visiting www.AdvantageDental.com. If you have questions, you are also welcome to contact Advantage at (866) 268-9616 or via e-mail at ProviderRelations@AdvantageDental.com. Please complete the form below and return it to Advantage, (See address and fax number at the top of this form). A representative will contact you personally.

☐ Yes, I would like more information on how to become an Advantage Dental Network provider.

Dentist name: _____

Office address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Office manager: _____

Specialties: _____

Signature: _____ Date: _____