

Please consider my dentist for potential membership in the Dental Select network. I understand your dental network has the authority to make the final decision about membership approvals. I also understand my name may be mentioned as the person who referred the dentist to you.

Patient Information	
Date:	Plan:
Patient Name:	
Employer:	
Phone number:	Email:

Dentist Information	
Name:	
Address:	
City:	
State:	Zip Code:
Phone Number:	
Specialty:	

* Call your dentist to verify status of participation.

Please visit www.dentalselect.com or complete this form and submit to:

Corporate Office
5373 S. Green Street, 4th Floor, Salt Lake City, UT 84123
(801) 495-3000 - Toll Free 1-800-999-9789
Fax (801) 495-3368 - Toll Free Fax 1-888-673-5328