

CompBenefits, Corporation
200 West Jackson Blvd, 9th Floor
Chicago, IL 60606
Fax: 312-427-9558
Attn: Professional Relations

Please fill out the information requested below and we make every effort to recruit the dentist regarding participation in our networks.

Provider Nomination Request Form

Date: _____

Dentist Name: _____

Address:

Phone: _____

Specialty: _____

Member Name: _____

Group Name: _____

Plan: _____

Please be aware that although we will make every effort to recruit your nominated Dentist into your network of participating providers, we cannot guarantee that the Dentist will agree to join your CompBenefits network. You may inform your Dentist that you have given his or her name to CompBenefits and that someone from CompBenefits Professional Relations will contact them about participation. Your nomination is greatly appreciated.
