

# Preferred Provider Nomination Form

I would like to nominate my dentist for inclusion in the **Cypress Ancillary Preferred Provider** network. I understand that Cypress may use my name when contacting my dentist and inform him / her of my desire for them to join the network.

Date: \_\_\_\_\_

### Your Information:

Name: \_\_\_\_\_

Phone or Email: \_\_\_\_\_

Employer: \_\_\_\_\_

Plan name: \_\_\_\_\_

### Dentist Information:

Provider Practice Name: \_\_\_\_\_

Dentist Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

General Dentist       Specialist       Orthodontist

Please submit this form by:

Mail: Cypress Ancillary | Provider Relations | 7510 Shoreline Drive Stockton, CA 95219  
Fax: (209) 478-5614  
Email: Providerservices@cypressadmin.com

If you have any questions about participating in Cypress Ancillary Benefits' provider network, please do not hesitate to contact **Customer Service** at: **800-350-3989**

Please note that every effort will be made to consider your nomination. However, geographical network space, provider's response, or Cypress's qualifying guidelines may restrict provider qualification.