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.