EmblemHealth®

Dental Group Contract

Signature Page

PLEASE SELECT WHICH EMBLEMHEALTH DENTAL NETWORK(S) YOU WOULD LIKE TO JOIN.	
☐ **Preferred Plus**	☐ **Preferred** (includes the Preferred Premer and Dental Access plans, where applicable)

DENTIST		
By signing below, I agree to participate in the Preferred Plus and/or Preferred EmblemHealth Plan, Inc. dental networks and to be bound by all terms and conditions of the attached EmblemHealth Plan, Inc. Dental Preferred Plus and/or Preferred Dental Group Contract.		
Signature:		
Name/Title:		
On Behalf of (if applicable):		
Date:		
Address:		
City:	State:	ZIP:
Phone Number:	Fax Number:	
Office Email Address:		
DEA # (if applicable):	Tax ID:	
CAQH ID:	NPI:	

FOR EMBLEMHEALTH USE ONLY	
Signature:	Date:

RESET PRINT