

**PLEASE SELECT WHICH EMBLEMHEALTH DENTAL NETWORK(S) YOU WOULD LIKE TO JOIN.**☐ **Preferred Plus**☐ **Preferred**(includes the Preferred Premier 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 Individual Dentist 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:

NPI #:

CAQH ID:

**FOR EMBLEMHEALTH USE ONLY**

Signature:

Date: