EmblemHealth®

Individual Dentist Contract
Signature Page

PLEASE SELECT WHICH EMBLEMHEALTH DENTAL NETWORK(S) YOU WOULD LIKE TO JOIN.	
☐ **Preferred Plus**	☐ **Preferred** (which 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:
Phone Number:
Fax Number:
Office Email Address:
DEA # (if applicable):
Tax ID:
NPI #:

FOR EMBLEMHEALTH USE ONLY
Signature:
Date: