



DENTAL PROVIDER SELECTION FORM

Please fill out the below form with your dental office selection (dependents may choose separate facilities) and fax it to 703.518.8849 or mail it to Dominion National; Attn: Member Services Department; 251 18th Street South, Suite 900; Arlington, VA 22202. You may also nominate a provider in the bottom section.

All enrolled dependents (spouse or child) will be assigned to subscriber's facility unless otherwise specified.

Subscriber Information					
Sex	Last	First Name	M I	DOB <small>(mm/dd/yy)</small>	Dental Office
				/ /	

Dependent Information					
Sex	Last Name <small>(if different)</small>	First Name	M I	DOB <small>(mm/dd/yy)</small>	Dental Office <small>(if different)</small>
1.				/ /	
2.				/ /	
3.				/ /	
4.				/ /	
5.				/ /	
6.				/ /	
7.				/ /	
8.				/ /	



PROVIDER REQUEST FORM

Dominion Dental Services, Inc. d/b/a Dominion National continues to expand its provider network to satisfy the increased demand for their services in the area. Should you wish a specific dentist to be contacted for consideration by the program, please supply the following:

Dentist Name _____

Address _____

City, State Zip _____

Phone _____

Specialty: GP Ortho Endo Perio Pedo Prost

Referral from: Subscriber Name _____

Participating Provider Name _____