CIGNA DENTAL

Dentist Nomination Form

Dentist First & Last Name_____ *(Required)*

Dentist Type: ☐ DHMO ☐ DPPO *(Please Check One)*

Dental Specialty: ☐ General Dentist ☐ Specialist (i.e. Endodontics, Oral Surgery, Orthodontics, Dental Therapist, Hygienist, Denturist) *(Please Check One)*

Dentist Contact Information:

Street Address _____ *(Required)*

Suite _____ *(Required if applicable)*

City _____ *(Required)*

State _____ *(Required)*

Zip Code _____ *(Required)*

Phone _____ *(Optional)*

Fax _____ *(Optional)*

Customer Name (First and Last Name) _____ *(Required)*

Customer phone number _____ *(Required)*

Customer email address _____ *(Required)*

Employer Name _____ *(Required)*

Employer group number _____ *(Required)*

Please submit the completed form to any one of the following:

Mail: Cigna Dental

Attn: National Contracting Unit
4616 US Hwy 75 S
Denison, TX 75020

E-mail: DentistEnrollment@Cigna.com

Fax#: 860-771-4228

We look forward to reviewing your request. Please allow 10–15 business days for us to further research and handle. We will contact you once we have updates to share. If you need immediate assistance, please call us at **1.800.280.9622**. We'll be happy to help you.

Together, all the way.®

Cigna®