



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.®



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