



Provider Nomination Form

At Solstice Benefits, we are always looking for quality providers to add to our exceptional network of dentists. If you have a recommendation for someone to add, please complete the form below, then e-mail/fax it to us at the contact information listed.

| | | |
|--------------------------|--------|--------|
| Date: | | |
| Name of Provider: | | |
| Type of Provider: | | |
| Name of Office: | | |
| Office Phone Number: | | |
| Name of Subscriber: | | |
| Subscriber Contact Info: | Phone: | Email: |
| Subscriber Group Name: | | |
| Plan type (circle one): | HMO | PPO |

We appreciate your input and will contact you in the future with any questions or further updates. Thank you!

Although we make every effort to add providers to our networks, we cannot guarantee that our plan will be accepted.

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