Provider Nomination Form

FAX: (727) 683-8810
Email: providerrelations@advanticabenefits.com

Part I: Requestor Information				
Last Name	First Name	MI	Employer Name	Email
Street Address	City	State	Zip	Phone
Part II: Provider Information				
Last Name	First Name	MI	Practice Name	Email
Street Address	City	State	Zip	Office Phone

Part III: Specialty

Dental		**Vision**
☐ General	☐ Orthodontist	☐ Ophthalmologist
☐ Endodontist	☐ Pediatric	☐ Optical
☐ Oral Surgery	☐ Periodontist	☐ Optometrist

☐ I hereby authorize Advantica to reference my name when contacting provider office.

Please mail this form to:

Advantica
Attn: Provider Relations
19321-C Hwy 19 North, Suite 320
Clearwater, FL 33764