



Provider Nomination Form

We are always looking to add new dental providers to our network. If you would like to have your dentist added to our network, please complete the form below and fax or mail it to us. We will then contact the dentist and invite them to participate in our network.

Provider Information:

Provider Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: (_____) _____

Type of Provider: _____

Member Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Telephone Number: (_____) _____

Email Address: _____

Employer: _____

Please fax or mail this form to:
American Dental Professional Services
Attn: Network Development
9054 N. Deerbrook Trail, Milwaukee, WI 53223
Phone: 888-540-9488
Fax: 414.716.0083

Or send the information via email to: amdps@amdpi.com