City of Chesapeake

Provider Nomination Form

Today's Date_____

Patient Name_____

Address_____

City_____State_____Zip_____

Phone Number(_____)_____BB

My name may be used when contacting my dentist?

Yes No

Dentist Name_____

Dentist Address_____

City_____State_____Zip_____

Dentist Phone Number(____ _____BBB

Email or Fax Nomination Form to:

providernomination@anthem.com

Attn: Network Development
Fax # 877-329-6459

Anthem BlueCross BlueShield