United Healthcare | Dental Benefit Providers®

Provider packet request form

Please complete all fields and email the completed form to the email address* that applies to your state and region, using the regional map as your guide.

Please indicate in the email subject line - **Packet Request [State] [County].**

Dentist first name:	Dentist last name:	Associate/owner:	NPI:	Specialty:

Please check the dental network(s) that you wish to join:

PPO (Commercial) Medicare Medicaid DHMO/Direct Compensation

Contact name:	**Email:**	**Phone number:**

Practice name:	**Practice TIN:**	
Address:	**County:**	
City:	**State:**	**ZIP code:**
Mailing address: (if different from practice address)		
City:	**State:**	**ZIP code:**

Are the dentists above being added to an existing participating location? Yes No

Is this a new practice location? Yes No

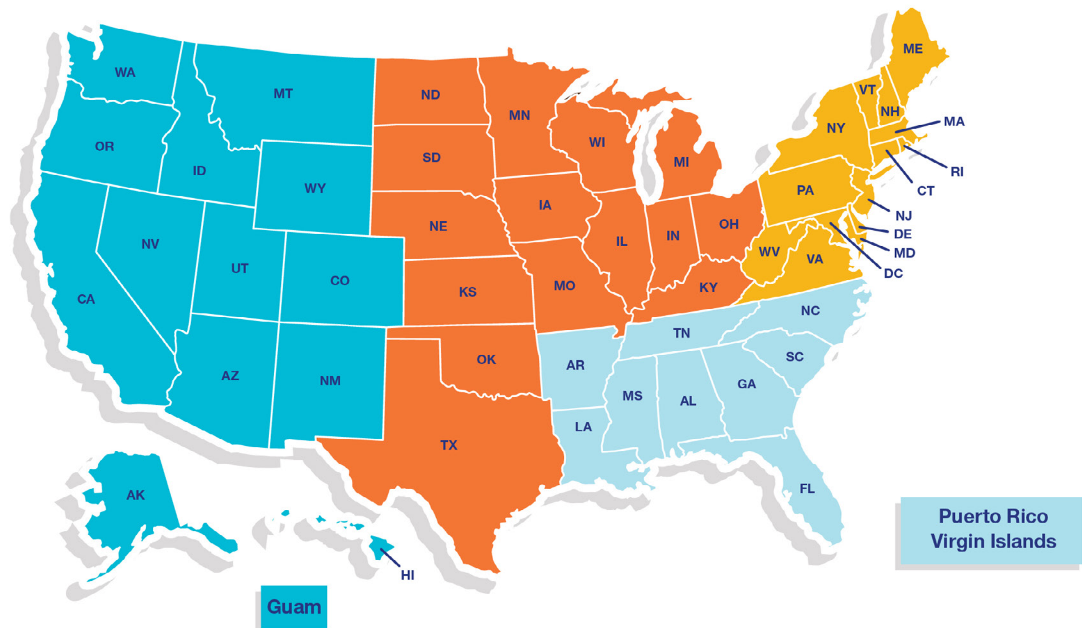
Regional map

West Region
we_packetrequest@uhc.com

Central Region
ce_packetrequest@uhc.com

Southeast Region
se_packetrequest@uhc.com

Northeast Region
ne_packetrequest@uhc.com



***Important Note:** We only process provider packet requests at the email addresses above. For assistance with other inquiries, please reach out to our Provider Services Team at **800-822-5353.**

PCA-1-22-01164-E&I-WEB_04072022

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