

# Provider packet request form

Please complete all fields and email the completed form to the email address\* that applies to your state and region.  
(Refer to the **Regional map** below 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

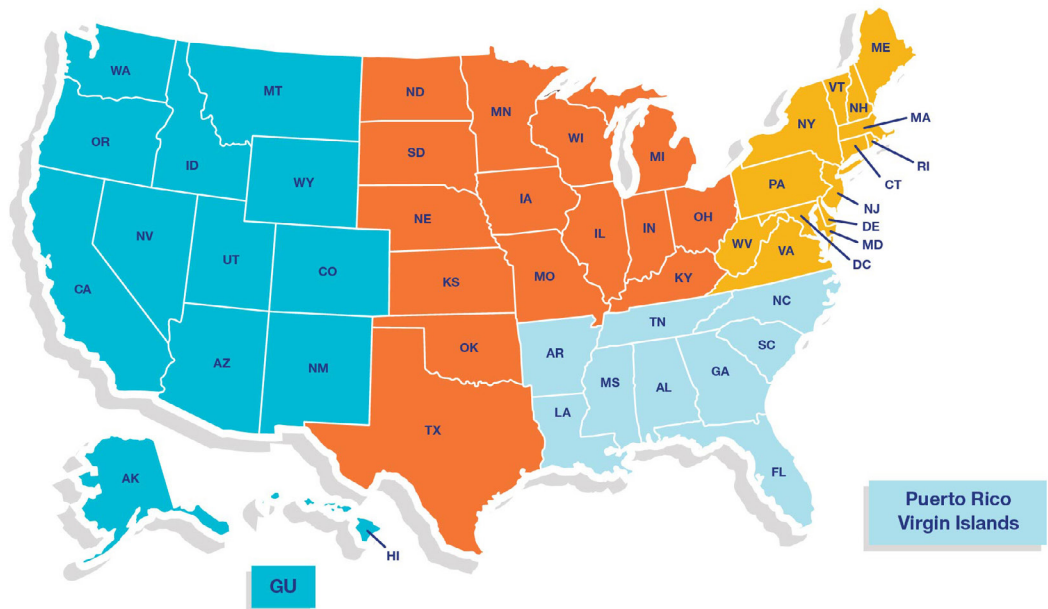
 Medicaid

 DHMO/Direct Compensation

<b>Email:</b>		<b>Contact name:</b>	
<b>Practice name:</b>		<b>Phone number:</b>	
<b>Address:</b>		<b>County:</b>	
<b>City:</b>		<b>State:</b>	<b>ZIP code:</b>
<b>Mailing address: (if different from practice address)</b>			
<b>City:</b>		<b>State:</b>	<b>ZIP code:</b>
<b>Are the dentists above being added to an existing participating location?</b>		Yes	No
<b>Is this a new practice location?</b>		Yes	No

## Regional map

<b>West Region</b> we_packetrequest@uhc.com
<b>Central Region</b> ce_packetrequest@uhc.com
<b>Southeast Region</b> se_packetrequest@uhc.com
<b>Northeast Region</b> ne_packetrequest@uhc.com



**\*Important Note:** Only requests to join our network are processed through the email addresses above. If your request does not relate to a provider joining our network or a packet request, please reach out to us at **800-822-5353** for further assistance.