DELTA DENTAL®

OPT-OUT NOTIFICATION FORM
Delta Dental Medicare Advantage™ Network

As an authorized representative of the dental practice named below, I am opting out of the Medicare Advantage Network Addendum to Delta Dental of Arizona's Participating Dentist Agreement. I understand that my decision to opt out of the addendum means my dental practice will not participate in the Delta Dental Medicare Advantage network. This opt-out notification is valid for all dentists practicing at the location listed on this form.

Organization/Practice Name

Tax ID Number

Physical Street Address (includes Suite)

City, State, Zip Code

List all participating dentists at the practice location (attach another piece of paper if necessary):

Dentist First Name	Dentist Last Name	AZ License Number

Printed Name of Authorized Representative

Signature of Authorized Representative

Title of Authorized Representative

Date

Please return the completed form to:

- **Email**: medicarecredentialing@deltadentalaz.com
- **Fax:** 602.548.5067
- **Mail**: Delta Dental of Arizona
  Medicare Advantage Credentialing Team
  P.O. Box 43000
  Phoenix, AZ 85080-3000