DELTA DENTAL

OPT-OUT FORM
DELTA DENTAL OF KENTUCKY MEDICARE ADVANTAGE NETWORK

I choose to opt-out of the Medicare Advantage Supplement to Delta Dental of Kentucky's PPO Participating Dentist Agreement.

I understand that Medicare Advantage patients will not have benefit coverage if treated by me as a non-network Medicare Advantage provider.

Dentist Name: _____

Kentucky License Number: _____

Dentist Signature: _____

Date: _____

List all locations impacted by your opt-out notification. (attach an additional page if needed)

Business/Practice Name	Address	Tax ID Number

Please return the completed form to:

- Email: medicareadvantage@deltadentalky.com
- Fax: 877.224.2441
- Mail: Delta Dental of Kentucky
  Attn: Provider Relations
  PO Box 242810
  Louisville, KY 40224-2810