



Dental Carrier Enrollment

Welcome to the Dental Wellness Plan. Please see the information included in this mailing about your dental carrier options. You must select one dental carrier to enroll with. If you do not select one, you will be enrolled with the dental carrier listed on your enrollment letter. After you complete this form, please return it in the postage paid envelope. You do not need a stamp to return this form by mail. You may also fax your completed form to 515-725-1351.

Complete this form with blue or black ink.

Name of Person to Enroll	Date of Birth	ID Number	Check One Dental Carrier	
			<input type="checkbox"/> Delta Dental	<input type="checkbox"/> MCNA Dental
			<input type="checkbox"/> Delta Dental	<input type="checkbox"/> MCNA Dental
			<input type="checkbox"/> Delta Dental	<input type="checkbox"/> MCNA Dental
			<input type="checkbox"/> Delta Dental	<input type="checkbox"/> MCNA Dental

Reason for changing your dental carrier: _____

Your address (Street, City and Zip Code)

Your Phone Number

Sign Here

If you have questions about how to complete this form, call Iowa Medicaid Member Services at **1-800-338-8366** or locally in the Des Moines area at **515-256-4606**, Monday through Friday, from 8 a.m. to 5 p.m.

*Para solicitar este documento en español, comuníquese con Servicios para Miembros al teléfono **1-800-338-8366** de 8 a.m. a 5 p.m., de lunes a viernes.*

For telephone accessibility assistance if you are deaf, hard-of-hearing, deaf-blind, or have difficulty speaking, call Relay Iowa TTY at 1-800-735-2942.