



QCD OF AMERICA®
The Dental and Vision Benefit Program

DENTIST REFERRAL FORM

QCD OF AMERICA® adds dentists to the affiliated dental team through the referrals of new and existing members. After you review the most current affiliated dental team listing, please provide us with your suggestions for new dentist affiliates that are currently NOT listed on the network of affiliated dentists.

Your Name

Your Telephone Number

Your Employer

Dentist's Name

Dentist's Address

City, State, Zip Code

Dentist's Telephone Number

This form is for new and existing QCD members to suggest new dentists for QCD to contact for possible affiliation with the dental program. All dentists will be contacted immediately, however, all dentists must meet QCD's qualification requirements prior to affiliation.
