SIGN UP YOUR DOCTOR / HOSPITAL

with

Dear Provider: You have received this because a patient wishes to use your services, but you are not currently a USA Managed Care Organization preferred provider. Please take a moment to print, complete the form in its entirety and fax it to **1-512-306-1369.** A USA representative will contact you.

Provider Name: _____
MD, DO, PhD, Other: _____

Specialty(ies): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: ( ) _____

Insured's Name: _____ Phone: ( ) _____

Employer's Name: _____

Insurance Co. _____

Comments: _____

*Although USA will make every attempt to contract with a requested healthcare provider, this is NOT a guarantee of provider participation. All healthcare providers must meet USA's credentialing standards prior to acceptance into the network.

FOR INTERNAL USE ONLY: ☐ Priority 1 ☐ Direct Client #