USA Managed Care Organization
The National Networks of Choice

PROVIDER APPLICATION
Arkansas
Please complete ONE application for each Practitioner

DIRECTORY/BILLING INFORMATION				
Last Name	First Name		M.I.	Jr., Sr., as applicable
Gender (M/F)	Birth Date (mm/dd/yy)	Professional Degree	NPI:	Social Security Number (Billing Purposes ☐ Yes ☐No)
Clinical Name or D.B.A. Name				Tax I.D. Number (Billing Purposes ☐ Yes ☐ No)

NP, CRN FA or PA Supervising/Authorizing Physician:

Last Name, First Name, Prof. Degree _____

Address and Phone _____

Office Location (Attach additional directory addresses if applicable) Address: _____ City, State, Zip: _____	Phone: (_____) _____ Fax: (_____) _____ E-mail : _____
Billing Address (if different from above) Address: _____ City, State, Zip: _____	Billing Phone: (_____) _____ Fax: (_____) _____ Repricing Statement E-mail : _____

ACCEPTING NEW MEDICARE PATIENTS	OFFERS TELE-HEALTH	LANGUAGE SPOKEN	
☐ YES ☐ NO	☐ YES ☐ NO	☐ English Only	☐ Secondary Language _____

SERVICES AND SPECIALTIES PROVIDED AND BILLED BY PROVIDER (Please Check All That Apply)

☐ Emergency Medicine	☐ Hand Surgery	☐ Head and Neck Surgery	☐ Other _____
☐ Neuro/Spine Surgery	☐ Occupational Medicine	☐ Occupational Therapy	☐ Other _____
☐ Physical Therapy	☐ Plastic Surgery	☐ Reconstructive Surgery	☐ Other _____

CONSENT/REPRESENTATIONS AND WARRANTIES

I authorize USA to consult with hospital administrators, members of medical staffs, malpractice carriers and other persons to obtain and verify my credentials and qualifications as a provider. I release USA and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

Applicant's Signature: _____ Date: _____

Applicant's Printed Name: _____

☐ AR State Board Release form included.

Please return this form to:

USA Managed Care Organization, Inc.,
Attn: Network Development
4609 Bee Caves Road, Suite 200, Austin, Texas 78746

AUTHORIZATION AND RELEASE

I hereby authorize the Arkansas State Medical Board to provide my credentialing information gathered by the Board to **USA MANAGED CARE ORGANIZATION, INC**. (a Credentialing Organization) with whom I am affiliating and seeking privileges.

This Authorization shall remain in effect for a period not to exceed two (2) years unless revoked by me in writing.

Typed or Printed Name of Physician: _____

Licensure Number: _____

Physician Signature: _____

Date Signed: _____ / _____ / _____
(month) (day) (year)

*** THIS DOCUMENT DOES NOT AUTHORIZE THE ARKANSAS STATE MEDICAL BOARD TO RELEASE INFORMATION COLLECTED TO THIRD PARTIES EXCEPT AS LATER AUTHORIZED BY THE ABOVE PHYSICIAN AND ARKANAS LAW.**