



## SIGN UP YOUR DOCTOR / HOSPITAL

**Dear Insured:** To request your provider become a USA Managed Care Organization preferred provider, please take a moment to print, complete the form in its entirety and email to [providerenrollment@usamco.com](mailto:providerenrollment@usamco.com). A USA representative will contact your provider to invite them to join the Network.

Provider Name: \_\_\_\_\_  
(MD, DO, PhD, Other)

Specialty(ies): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Provider's contact name: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Next scheduled Appointment: \_\_\_\_\_

Comments: \_\_\_\_\_

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\* 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.