



## PROVIDER NOMINATION FORM

IF YOU WOULD LIKE TO NOMINATE A PROVIDER TO BECOME A PARTICIPATING PROVIDER WITH USFHP, COMPLETE THE FORM BELOW.

REQUESTOR INFORMATION	
Member Name:	
Mailing Address:	
City, State, Zip Code:	
USFHP Requestor:	
Referring Provider Name	
Referring Provider Specialty	
PROVIDER INFORMATION	
Name:	
Group Name:	
Specialty:	
Street Address:	
City, State, and Zip:	
County:	
Phone:	
Fax:	
Date:	

Comments:

---

---

---

Please send completed form to:

USFHP  
450 West 33<sup>rd</sup> Street  
New York, NY 10033  
800-241-4848 (Phone)  
212-356-4949(Fax)