Health Discount Program
Provider Nomination Form

Members: Would you like your health care provider to be part of our program?

We are always interested in adding qualified, caring professionals to our health care network. If your health care provider is interested in participating in the program:

- Ask the provider to complete the Health Care Professional Information section of this form (below). We cannot process the nomination without this information.
- Complete the Member Information section of the form and return it to us.

We will contact your health care professional promptly.

Note: A nomination by a member does not guarantee that the health care professional will be added to our discount program. Acceptance into the network depends on successful completion of the credentialing process and receipt of a signed contract from the health care professional. The application process may take three months or more from the time we receive the completed nomination form.

Providers: Be part of a winning team!

HealthAllies, Inc. (a UnitedHealth Group company) is a health discount program serving more than 15 million members nationwide. More than 500,000 health care practitioner locations and facilities nationwide participate in our program, in such specialties as medical, dental, vision and alternative care. Our program offers members pre-negotiated rates on products and services they purchase out of pocket. Members pay the pre-negotiated rate at the time of service, thereby bypassing the billing and claims process entirely.

We'd like to offer you an opportunity to increase your share of the growing consumer-directed market by joining our network of qualified health care professionals.

Please complete the Health Care Professional Information section of this form and return the form to the member for submission to us. We will forward it to the appropriate provider network.

HealthAllies, Inc.
P.O Box 1459
Minneapolis, MN 55414
Email address: ohacustomercare@optum.com

Member Information (*= Required Field):

Member Name*:_____ Member ID# (if applicable):_____

Person you spoke to at provider's office: _____

Health Care Professional Information:

Practitioner's Name:_____

Practitioner's Specialty:_____ National Provider Identifier #:_____

Address:_____ City, State, ZIP Code:_____

Office Phone Number:_____ Office Email Address: _____

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