



NATIONAL HEALTH FUND

6TH Floor, The Towers, 25 Dominica Drive, Kingston 5
Tel: (876) 906-1106 Fax: 906-1105 Toll-free 1-888-NHF-CARE
Website: www.nhf.org.jm

PHARMACEUTICAL DIVISION: Tel. (876) 923-6920/923-6926-8 Fax. 923 7159

PROVIDER APPLICATION FORM- DIAGNOSTIC SERVICES

Kindly complete the form and return original to the above address along with **the supporting documents**.

Tick the appropriate box for the HbA1c system you wish to obtain:

NycoCard Reader 11 SDA1c Care Analyser System Other

APPLICANT INFORMATION

1. Name of Applicant: _____
2. TRN (business/personal): _____ (attach a copy)
3. Professional Registration #: _____
4. Email Address: _____
5. Type of Business: Medical Practitioner Pharmacy Lab Other _____
6. Business Address (Street and Number): _____

7. Mailing Address (if different from above): _____

8. Telephone Number(s): Office: _____ Cell: _____ Fax: _____
9. Select the preferred method of submitting claims: Online Electronic Claims Manual Claims

OWNER(s) /DIRECTOR(s) INFORMATION

10). Name (s)	Tel. Number(s)	Occupation	Place of Employment	Email Address
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

11). Are you a Provider for any other Insurance Carrier/Private Plans? **Yes** **No**

12). If yes, indicate name(s) _____

13). Preferred method of Communication: **Email** **Fax** **Mail**

Name of Applicant	Signature	Position	Date
_____	_____	_____	_____

(Please print name) Company Stamp/Seal