



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

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 diagnostic service you wish to provide:

HbA1c

SDA1c Care Analyser System Other _____
(please specify name of device)

Prostate Specific Antigen (PSA) Test

Tick the appropriate box for the patients you wish to serve:

Private patients Public patients

N.B: All successful claims will be processed electronically

APPLICANT INFORMATION

1). Name of Facility/Region (where applicable): _____

2). Name of Health Professional/Designate: _____

3). Professional Registration #: _____ 4). Email Address: _____

5). TRN (business/personal): _____ (attach a certified copy)

6). Type of Business: Medical Practitioner Pharmacy Lab Other _____

7). Business Address (Street and Number): _____

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

9). Telephone Number(s): Office: _____ Cell: _____ Fax: _____

OWNER(S) /DIRECTOR(S)/RELEVANT PERSONNEL(S) IN CHARGE OF FACILITY INFORMATION
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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 Mail

Name of Applicant	Signature	Position	Date
_____	_____	_____	_____

(Please print name) Company Stamp/Seal