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
Email : providerrelations@nhf.org.jm | Website: www.nhf.org.jm

PROVIDER APPLICATION FORM- DIAGNOSTIC/SCREENING SERVICES

Instructions:

a) Kindly complete the form and return original to the above address along with **current certified copies** of the documents listed on page four (4):
b) All sections must be completed and the relevant ***supporting documents*** submitted for the application to be considered.

DIAGNOSTIC SERVICES OFFERED

Please tick the appropriate box for the diagnostic service you wish to provide:

☐ **HbA1c**

☐ **Healgen Model OG-H180 Analyzer** ☐ **Other** _____
(please specify name of device)

NB: Providers should tick the Healgen Model OG-H180 Analyzer box only if requesting the machine through the Fund. If a device is already in possession, please specify its name in the space provided.

☐ **Prostate Specific Antigen (PSA) Test** ☐ **Pap Smear Test** ☐ **ECG (Electrocardiogram)**

☐ **Mammogram** ☐ **Echocardiogram**

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): _____ **(copy required upon request)**

6). Type of Business: ☐ **Medical Practice** ☐ **Pharmacy** ☐ **Lab** ☐ **Other** _____

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

_____

7 (a) Indicate the # of locations for which you are applying: _____

Release date: March 20, 2014 Rev date: July 23, 2026 Rev #: 13

7 (b) If more than one location, list locations on page three

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

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

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Scan for Privacy Notice

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If applying for more that one location, kindly complete the below:

Location Name	Address	Telephone Number	Email Address

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CHECKLIST

The following represents the requirements for submission. Items “a” – “c” are required for all applications and item “d” is required for medical doctors and laboratories. Items “e” and “f” are to be submitted by pharmacy providers.

a) Certificate of Business Registration Registrar of Companies

b) Certificate of Incorporation and Articles of Incorporation

c) **F23** Notice of Appointment of/change of Directors (where applicable)

d) Certificate of Annual Registration issued by licensing/Regulatory body

e) Pharmacy Council Certificate of Registration of the Shop (for pharmacies)

f) Pharmacy Council Certificate of Registration of the Registering Pharmacist