



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 **current certified copies** of the following documents where applicable:

- Pharmacy Council Certificate of Registration of the Shop
- Pharmacy Council Certificate of Registration of the Registering Pharmacist
- Certificate of Business Registration Registrar of Companies
- F23 Notice of Appointment of/change of Directors
- Certificate of Incorporation and Articles of Incorporation

NB. All Doctors should submit a certified copy of their Annual Practising Certificate

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 Pap Smear Test

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):** _____

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**