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 CHANGE FORM- DIAGNOSTIC SERVICES

Kindly complete the **CHANGE** form and return original to the above address along with **current certified copies** of the following documents where applicable:

- Certificate of Annual Registration Form licensing/Regulatory body
- Pharmacy Council Certificates
- Certificate of Business Registration - Registrar of Companies
- Certificate of Incorporation and Articles of Incorporation
- **F23** Notice of Appointment of/change of Directors

N.B. Where there is a change, kindly submit supporting documents verifying this change

Indicate the change required

☐ **Change of Location** ☐ **Change of Owner/Director(s)**
☐ **Change of Medical Technologist** ☐ **Change in Name of Business**

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): ____

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

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