Liberty Health Cover

Service Provider Information Form

Important: please read the following before completing this application form

- Please write clearly using capital and block letters.
- It is compulsory to complete all the fields in this form.

Date D D M M Y Y Y Y

Practice / Dr / Facility name

Physical address

Postal code

Postal address (if different to physical address)

Postal code

CONTACT DETAILS

Name of primary contact person

Telephone (please include country and area code) +

Mobile number (please include country and area code) +

Fax number (please include country and area code) +

Emergency telephone contact number +

Email

Internet Access (tick correct) Yes ☐ No ☐

Preferred communication method (tick your selection(s)) ☐ Telephone ☐ Mobile ☐ Fax ☐ Email ☐ Post ☐ Hand delivery

SERVICES OFFERED (tick all that are applicable)

Facility speciality

☐ Cardiac ☐ Orthopaedic surgery ☐ Neurology surgery

☐ General surgery ☐ Paediatrics ☐ Trauma

☐ Maternity ☐ Medical ☐ Out-patient

☐ Other (specify)

Facility type

☐ In-patient ☐ Out-patient ☐ Emergency/ trauma

No. of beds No. of theatres

Levels of acuity

☐ Specialist ICU ☐ Cardiac ICU ☐ Paediatric ICU

☐ High care ☐ Maternity

GENERAL WARD

Number of service providers Medical officers General practitioners Specialists

Others Specify