Liberty Health Cover Service Provider Information Form



LIFE INVESTMENTS INSURANCE HEALTH PROPERTIES ADVICE

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Practice / Dr / Fac	ility name																												
Physical address																													
															Post							tal code							
Postal address (if different to physical address)																													
																Postal code													
CONTACT DE	TAILS																												
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 (t	ick correct)	Υ	/es		N	0																							
Preferred commu	nication me	thod	(tick	you	r sele	ction	(s))		Te	lepho	one		N	lobil	e		Fax			Em	ail		P	ost		Η	land	deliv	ery
SERVICES OFFERED (tick all that are applicable)																													
Facility speciality Cardiac					rdiac					Orthopaedic surgery							Neurology surgery												
General surgery Maternity Other (specify)							Paediatrics								Trauma														
							Medical								Out-patient														
Facility type In-patient							Out-patient								En	nerg	ency	/ tra	uma										
No. of beds									o. of t																				
Levels of acuity Specialist ICU							Ca	rdiac	: ICU					Pa	edia	tric l	CU												
High care									М	Maternity																			
GENERAL WA	RD																												
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