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.

Practice / Dr / Facility owner name

Physical address

Postal code

Postal address (if different from physical address)

Postal code

CONTACT DETAILS

Name of responsible person

Telephone numbers (please include country and area code) +

Cellphone numbers (please include country and area code) +

Fax numbers (please include country and area code) +

Emergency contact telephone number +

E-mail address

Internet access (tick correct) YES NO

Preferred communication method (tick your selection ☐ Telephone ☐ Mobile ☐ Fax ☐ E-mail ☐ Post ☐ Hand delivery

BANKING DETAILS (PLEASE COMPLETE TO ENSURE PAYMENT)

Account holder name

Account number

Account type ☐ Savings ☐ Cheque ☐ Transmission Other

Bank

Branch name

Branch code Swift code

NIB (If applicable)

IBAN (If applicable)

Please attach the following documents

- Copy of the account holder's Identity Document/Passport/Driver's Licence.
- Copy of a bank stamped letter confirming banking details not older than 3 months.

DISCLAIMER: No banking details will be accepted without the abovementioned mandatory documents.

SERVICES OFFERED

Facility speciality
- [ ] Cardiac
- [ ] Orthopaedic surgery
- [ ] Neurology surgery
- [ ] General surgery
- [ ] Paediatrics
- [ ] Trauma
- [ ] Maternity
- [ ] Medical
- [ ] Out-patient
- [ ] Other ______

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 ______

Specialists ______

General practitioners ______

Others ______

PROVIDER DECLARATION

I hereby declare the above to be true

Registration/Practice no. ______

Name ______

Signature ______ Date D D M M Y Y Y Y

Provider stamp

FOR OFFICIAL USE

FRONT OFFICE DECLARATION

I hereby declare that I have received and verified the above information with the required mandatory documents.

Name ______

Signature ______ Date D D M M Y Y Y Y

Front office stamp

Submitted to email address ______