

Liberty Health Cover Service Provider Information Form



LIBERTY

LIFE INVESTMENTS **HEALTH** CORPORATE PROPERTIES ADVICE

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	<input type="text"/>	<input type="text"/>
Physical address	<input type="text"/>	<input type="text"/>
Postal address (if different from physical address)	<input type="text"/>	Postal code <input type="text"/>

CONTACT DETAILS

Name of responsible person	<input type="text"/>
Telephone numbers (please include country and area code)	+ <input type="text"/>
Cellphone numbers (please include country and area code)	+ <input type="text"/>
Fax numbers (please include country and area code)	+ <input type="text"/>
Emergency contact telephone number	+ <input type="text"/>
E-mail address	<input type="text"/>
Internet access (tick correct)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Preferred communication method (tick your selection)	<input type="checkbox"/> Telephone <input type="checkbox"/> Mobile <input type="checkbox"/> Fax <input type="checkbox"/> E-mail <input type="checkbox"/> Post <input type="checkbox"/> Hand delivery

BANKING DETAILS (PLEASE COMPLETE TO ENSURE PAYMENT)

Account holder name	<input type="text"/>
Account number	<input type="text"/>
Account type	<input type="checkbox"/> Savings <input type="checkbox"/> Cheque <input type="checkbox"/> Transmission <input type="checkbox"/> Other <input type="text"/>
Bank	<input type="text"/>
Branch name	<input type="text"/>
Branch code	<input type="text"/> Swift code <input type="text"/>
NIB (If applicable)	<input type="text"/>
IBAN (If applicable)	<input type="text"/>

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	<input type="checkbox"/> Cardiac	<input type="checkbox"/> Orthopaedic surgery	<input type="checkbox"/> Neurology surgery
	<input type="checkbox"/> General surgery	<input type="checkbox"/> Paediatrics	<input type="checkbox"/> Trauma
	<input type="checkbox"/> Maternity	<input type="checkbox"/> Medical	<input type="checkbox"/> Out-patient
	<input type="checkbox"/> Other	<input type="text"/>	
Facility type	<input type="checkbox"/> In-patient	<input type="checkbox"/> Out-patient	<input type="checkbox"/> Emergency/Trauma
No. of beds	<input type="text"/>		
No. of theatres	<input type="text"/>		
Levels of acuity	<input type="checkbox"/> Specialist ICU	<input type="checkbox"/> Cardiac ICU	<input type="checkbox"/> Paediatric ICU
	<input type="checkbox"/> High care	<input type="checkbox"/> Maternity	

GENERAL WARD

Number of service providers	Medical officers	<input type="text"/>
	Specialists	<input type="text"/>
	General practitioners	<input type="text"/>
	Others	<input type="text"/>

PROVIDER DECLARATION

I hereby declare the above to be true

Registration/Practice no.	<input type="text"/>	
Name	<input type="text"/>	
Signature	<input type="text"/>	Date <input type="text"/>
Provider stamp	<input type="text"/>	

FOR OFFICIAL USE

FRONT OFFICE DECLARATION

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

Name	<input type="text"/>	
Signature	<input type="text"/>	Date <input type="text"/>
Front office stamp	<input type="text"/>	
Submitted to email address	<input type="text"/>	