PROVIDER APPLICATION FORM
EBD 197

PLEASE USE BLOCK LETTERS TO COMPLETE THIS FORM AND WRITE LEGIBLY.

Section A

NAME OF APPLICANT/PROVIDER[2]

TYPE MEDICAL ☐ OPTICAL ☐ DENTAL ☐ PHARMACY ☐ LABORATORY ☐ RADIOLOGY ☐

SPECIALTY

OTHER

REGISTRATION AUTHORITY

PROFESSIONAL REGISTRATION NO. **TRN**[1] ___ — ___ — ___

Section B

PRACTICE LOCATION ADDRESS

CITY **PARISH**

OPERATING DAYS & HOURS _____

IS LOCATION CURRENTLY IN OPERATION? YES ☐ NO ☐ **NAME OF CONTACT PERSON** _____

TELEPHONE ___ — ___ — ___ **FAX** ___ — ___

EMAIL _____ @ _____ . _____

Section C

ADDITIONAL PRACTICE LOCATION

CITY **PARISH**

OPERATING DAYS & HOURS _____

IS LOCATION CURRENTLY IN OPERATION? YES ☐ NO ☐ **NAME OF CONTACT PERSON** _____

TELEPHONE ___ — ___ — ___ **FAX** ___ — ___

EMAIL _____ @ _____ . _____

Section D

MAILING ADDRESS, IF DIFFERENT FROM PRACTICE LOCATION

CITY **PARISH**

HAS YOUR LICENCE EVER BEEN REVOKED OR SUSPENDED? YES ☐ NO ☐

IF YES, PROVIDE PROOF OF REINSTATEMENT _____

Additional information on reverse side

PROVIDER'S SIGNATURE _____ **DATE** _____

ADDITIONAL PROVIDER'S SIGNATURE _____ **DATE** _____

NOTE

1. For healthcare professionals, **EVIDENCE OF CURRENT REGISTRATION** with Medical, Dental, Pharmacy, Nursing Councils or any other body authorizing the applicant to practise in Jamaica IS REQUIRED.
2. For pharmacies, laboratories, diagnostic facilities and medical centres, we require **EVIDENCE OF REGISTRATION UNDER THE COMPANIES ACT indicating name(s) of owner(s).**
3. All provider locations must be in operation.
4. Please supply a certified English translation for any foreign language documentation.

REQUIREMENTS

MEDICAL

1. Current Annual Practising Certificate (issued by Medical Council)

SPECIALIST

1. Current Annual Practising Certificate (issued by Medical Council)
2. Academic Qualification of Specialty

DENTAL

1. Current Annual Dental Certificate (issued by Dental Council)

OPTICAL

1. Academic Qualification (from university)
2. Optometrist Registration

PHARMACY

1. Form E (Registration of Shop as a Pharmacy, issued by Pharmacy Council)
2. Form H (Current Registration of Pharmacist)
3. Ability to submit health insurance claims electronically
4. Contractual agreement with National Health Fund (NHF) for coordination of benefits (COB)

LABORATORY

1. Current Council of Professions Supplementary to Medicine Certificate (of the Medical Technologist)
2. Certification by the Ministry of Health's Standard & Regulations Department

RADIOLOGY

1. Current Council of Professions Supplementary to Medicine Certificate (of the Radiology Technologist)
2. Certification / Approval from Medical Physicist

Section E

ADDITIONAL PRACTICE LOCATION

CITY **PARISH**

OPERATING DAYS & HOURS _____

IS LOCATION CURRENTLY IN OPERATION? YES ☐ NO ☐ **NAME OF CONTACT PERSON** _____

TELEPHONE ___-___ **FAX** ___-___

EMAIL _____ @ _____ . _____

FOR INTERNAL USE ONLY

Assigned Provider No.: ; ;

Application Approved By: _____ **Date:** _____

G U A R D I A N L I F E L I M I T E D – M E D E C U S H E A L T H

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