LIBERTY

In it with you

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 Email 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 Currency code

NIB (if applicable)

IBAN (if applicable)

Please submit ALL the following documents with this application form to verify your bank details:

1. A copy of the account holder's identity document, passport or valid driver's license.
2. Copy of a bank stamped letter confirming banking details not older than 3 months.

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

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

Specialists

General practitioners

Others

Specify

PROVIDER DECLARATION

I hereby declare the above to be true

Registration/Practice no.

Name

Signature

Date signed Y Y Y Y M M D D

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 signed Y Y Y Y M M D D

Front office stamp

Submitted to email address