OSUN HEALTH INSURANCE SCHEME

APPLICATION FOR ACCREDITATION AS A SERVICE PROVIDER

Application Form Receipt No./Date ....

NAME OF ORGANISATION____

OFFICE/FACILITY ADDRESS____

____

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POSTAL ADDRESS____

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STATE____

LOCAL GOVERNMENT AREA____

TELEPHONE____

E-MAIL________________________**WEBSITE**___________________________

MEDICAL DIRECTOR/C.E.O.____

PROFESSIONAL QUALIFICATION(HCP)_____________________________________

OPERATING QUALIFICATION (HMO, TPA) __________________________________

REGISTRATION NUMBER & YEAR____

STATE LICENCE NUMBER (IF APPLICABLE)_________________________________

DATE OF ISSUE____

EXPIRE DATE ____

TYPE OF SERVICE BEING APPLIED FOR:

HMO TPA HCP ICT

CATEGORY OF SERVICE BEING APPLIED FOR

PRIMARY SECONDARY BOTH

AUTHORISED SIGNATURE(S)____

NAME(S)____

COMPANY SEAL (IF ANY)____

DATE____

DECLARATION

I/We... hereby certify that this organization is incorporated and further certify that the above information is true and correct. I/We hereby give undertaking that upon grant of the accreditation, I/We shall abide by the terms and conditions of accreditation as issued and revised from time to time and the appropriate penalty applied if it is established that I/We have been granted accreditation based on false information.

SIGNED_____________________________DATE:_________________________________

COMPANY SEAL/DATE____

FOR OFFICIAL USE ONLY

ORGANISATION____

DATE OF ISSUE OF APPLICATION FORM ____

RECEIPT NO____

DATE OF RETURN OF APPLICATION FORM____

NAME____

SIGNATURE_______________________________DATE:_____________________________