IMO STATE HEALTH INSURANCE AGENCY

HEALTHCARE SERVICE PROVIDERS' ENROLLMENT/PARTNERSHIP FORM

PART A: FACILITY INFORMATION

FACILITY NAME:_____

FACILITY OWNER: _____

FACILITY TYPE:_____

LOCATION/ADDRESS:_____

LGA: _____ WARD:_____

TYPE OF HEALTHCARE SERVICES PROVIDED (Thick where applicable) Inpatient ☐ Outpatient ☐

STAFF STRENGHT

NUMBER OF HEALTHCARE WORKERS: _____

NUMBER OF NON-HEALTHCARE WORKERS: _____

NAME OF DESK OFFICER /CORRESPONDENT: _____

PHONE: _____ EMAIL:_____

FEE PAID FOR ENROLLMENT (non-refundable) _____NAIRA

AMOUNT IN WORDS _____

(MODE OF PAYMENT) BANK TELLER NO: _____ DATE: _____

ATTESTATION

I , _____ do declare that the information provided above is accurate and true to the best of my knowledge, I also append my signature in conformity with the terms/conditions provided by IMSHIA.

SIGNATURE:_____ DATE:_____

PART B : OFFICE USE

IMSHIA STAFF/RESIPIENT _____

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SIGNATURE:_____ DATE:_____