Sagicor Life Jamaica Limited
Provider Application

Application Type

- ☐ New Provider
- ☐ Change of Provider Location
- ☐ Additional Location for Provider
- ☐ Change of Ownership

APPLICATION DATE:

Type of Entity (select one):

- ☐ Sole proprietor
- ☐ Partnership (attach copy of agreement)
- ☐ Government
- ☐ Limited Liability Company (attach copy of articles of incorporation)

1) Legal name of Applicant or Provider (First/Middle/Last)

2) Mother's Maiden Name

3) Government Issued ID Type (PP/DL, attach copy)

ID #_____

Expiry Date_____

Country of Issue_____

4) Applicant's Date of Birth

5) Gender

☐ Male ☐ Female

6) Country of Birth (if not Jamaica, attach naturalization document or work permit)

7) Applicant's Home Address

8) Business Name

9) Telephone

Landline:

Cellular:

Fax:

10) Business Address

11) Email Address

12)Website Address

13) Mailing Address (if different from Primary Business Address)

14) Previous/Other Address (complete this part only if you have changed location or adding a new location)

15) Professional Registration Number (attach copies of <u>CURRENT</u> relevant registration documents)	**16) Taxpayer Registration Number**

17) List Professional Degrees/Certifications and Granting Institution (attach certified copies of diplomas/certificates)

18) Do you have current Hospital Privileges?

☐ Yes ☐ No ☐ Not Applicable

If Yes, please list the names and addresses of the institutions:

19) Have you ever had your professional registration or previous provider status (with Sagicor any other Insurance Carrier suspended?

☐ Yes ☐ No

If yes, please give details, attach additional sheet if necessary:

20) List the countries in which you have practiced and the period?

21) Specialty _____

22) Declaration and Authorization for Sharing of Information

I solemnly declare that the foregoing information and the information on all attachments are true, accurate, and complete to the best of my knowledge and belief and that I am authorized to sign this application.

I understand that the failure to disclose the required information, or the disclosure of false information, shall result in the denial of the application for Sagicor Provider Status or shall be grounds for termination of Provider Status which shall include the deactivation of all provider numbers used to gain reimbursement from Sagicor-administered Health Plans.

I hereby further declare that I will abide by all Sagicor regulations and procedures as published in the Sagicor Provider Manual, including the requirements for record-keeping, disclosure of information and allowing verification of claims submission records.
I agree to make available, during regular business hours, all records concerning the provision of Health Care Services to Sagicor Health Plan Members to any duly authorized representative of Sagicor Life Jamaica

I understand and agree that the information I provide in this form and from time to time, including information regarding my Provider Record and Claims Transactions with you (Provider Information) may be used for the following purposes: to confirm my identity, to augment and update currently held information, to provide me with accurate and up-to-date services, to manage and assess the company's risks, to satisfy information requests, and to meet legal and regulatory requirement.

I further understand and agree that my Provider Information may be shared within the Company which includes its parent , subsidiaries, associated companies and affiliates, with third party service providers, credit bureaus and Regulators in and outside of the jurisdictions in which Sagicor does business for the purposes above and as may be required by law. I hereby warrant that the information provided herein is accurate and consent to the sharing and disclosure of my Provider Information for the purposes provided herein and as Sagicor may require from time to time.

Printed Name of Applicant:

Signature:

Date:

General Site Requirements

Areas of Assessment:

- Signage
- General surroundings
- Reception Area
    - Receptionist Area
    - Filing System
    - Waiting Area
    - Rest Room
    - Medical Scale
    - Bin
    - Provider Access System (Swipe Card System)
- Consultation/Doctor's Office
    - Desk & Chair
    - Couch (Stirrup)
    - Stool
    - Hand washing Facilities
    - Trolley (drugs)
    - Instruments
- Treatment Room
    - Oxygen set up
    - Suction set up
    - Cupboard with sterile packs
    - Drugs
    - Sterilizer
    - Trolley / Couch
    - Bins with cover

The above are general requirements, additional assessment is done base on the area of specialty.