TARABA STATE CONTRIBUTORY HEALTH INSURANCE AGENCY

Healthcare Service Providers' Enrolment/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 ____

SIGNATURE:____________________ DATE:____________________

Former Sunrise Office, Old Commissioners Quarters
off Ahmalu Bello way, Jalingo. | +234 703 0550 097

- THIS FORM IS NOT FOR SALE -