

Application for Provider Facilities

THIS APPLICATION MUST BE COMPLETED FULLY USING BLOCK CAPITALS



1. Provider details

Name:	<input type="text"/>
Correspondence address:	<input type="text"/>
Postcode:	<input type="text"/>
Email address:	<input type="text"/>
Telephone number:	<input type="text"/>
Fax number:	<input type="text"/>

2. Specialist in which field

For example: surgeon, anaesthetist.

3. Fee schedule used

CIGNA	<input type="checkbox"/>	BUPA	<input type="checkbox"/>
WPA	<input type="checkbox"/>	AVIVA	<input type="checkbox"/>
Other (please specify)	<input type="text"/>		

4. Complete appropriate section according to status

GMC Membership Number:	<input type="text"/>
Licence Number:	<input type="text"/>
Registration Number:	<input type="text"/>

5. Provider banking details

Invoices are normally paid by Direct Credit to your Bank Account and we send a separate statement.

Please advise the following:

Bank Clearing Code:	<input type="text"/>
Bank Account Number:	<input type="text"/>

6. Declaration

Signed:	<input type="text"/>
Date:	<input type="text"/>
Name (BLOCK CAPITALS):	<input type="text"/>