ENROLLMENT FORM

Facility Name	
Clinic/Hospital / Pharmacy Name	
Group Name:	
HAAD/MOH /DHA Trade Licence No:	
Eclaim Link ID	
Provider type e.g. Hospital/Clinic/Pharmacy/ Laboratory/etc:(others pls.specify)	
Address and Location	
Building Name:	
Flat No:	
Floor No:	
PO Box No:	
Street Address:	
Emirate/Provience:	
Country:	
Telephone:	
Email for insurance:	
Fax for pre approvals:	
E-mail: for pre approvals:	
Mobile:	
Name of the Hospital/Clinic associated with: (applicable to pharmacy)	
Contact Person	
Name :	
Designation:	
Phone (mobile):	
E-mail:	
Authorized Signatory's details:	
Name :	
Designation:	
Name & address of the contact person for correspondence:	
Bank Details	
Account Name:	
Account Number:	
Bank Name:	
Bank Branch:	
SWIFT Code:	
IBAN Code:	

Hospital Infrastructure (yes/no)		Medical Clinic Infrastructure (yes/no)	
Number of beds		24h Emergency department	
24h Emergency department		CT Scan	
Intensive care		CT Scan 24h	
CT Scan		Laboratory	
CT Scan 24h		MRI	
Laboratory		X-Ray	
MRI		Ultrasound	
X-Ray		Mammography	
Ultrasound		PET SCAN	
Mammography		Others:	
PET SCAN			

Cardiac catheterization lab			
Maternity nursery			
Blood bank			
Burn unit			
Specialities Available (yes/no)			
Allergy and immunology		Ophtalmology	
ENT		Orthopedic surgery	
Cardiology		Orthetics and prosthetics	
Cardio-vascular surgery		Optometry	
Colon and rectal surgery		Pathology	
Dentist		Pediatric surgery	
Dermatology		Pediatrics	
Endicronology		Podology	
Family Practice/General practice/Primary care		Psychiatry	
Gastroenterology		Pulmonology	
General surgery		Radiotherapy	
Geriatrics		Radiology	
Hematology		Rehabilitation	
Infectious diseases		Rheumatology	
Intensive care		Sports medicine/ Physiptherapy	
Nephrology		Thoracic surgery	
Neurology		Urology	
Neurosurgery		Vascular surgery	
Obstetrics and gynecology		House call doctor	
Oncology		Plastic surgery/ cosmetic surgery/ reconstructive surgery	
Other - please specify:			