

PREMIER MEDICAID (NIGERIA) LIMITED – HMO
Primary Provider Registration Form (HCP 1)

Facility

Name of Provider:		
Address:		
City:	State:	
Phone Number:		
NHIS Registration No.:		E-mail:
No. of Beds:	No. of Doctors:	No. Reg. Nurses:

Personnel

Name of Medical Director:	
Specialization:	MDCN No.
Mobile (GSM) phone No:	

Other Doctors

Name	Specialization	MDCN No.	Mobile (GSM) Phone No.

Matron:	GSM No:
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Head of Admin:	GSM No:
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Bank Account Details (Preferably Intercontinental Bank Plc.)

Bank Name:
Branch:
Account Name:
Account Number:

Signature of Medical Director:	Date:
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Send to Head Office - Olive House, Block B, N6/53, Fajuyi Road, Adamingba, P. O. Box 29259 (Secretariat P. O.) Ibadan. Tel: 02-2410052, 2413750, 7510733, 08037866956, 08038547000, 08028275368, 08028255654, 08028908482, 08052919693. E-mails: info@premiermedicaid.com.ng, p_medicaid@yahoo.co.uk