Health Insurance Department

Health Insurance Plan / FutureCare Plan
New/Amended Provider Form

FOR OFFICIAL USE ONLY:
Processed by Provider Relations and Date (d/m/y)
____

*Approved by and Date (d/m/y):
____

Please submit one Provider Form for each healthcare practitioner that will bill for services

Facility or Group Practice Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Reason for Update: ☐ New Provider ☐ Registration Update ☐ No Longer Registered

Practitioner's New Information (*if changed*)

Practitioner Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Mailing Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Parish: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Postal Code: ☐☐☐☐

Telephone Numbers: ______________________________/__________________/______________________________
(Office) (Fax) (Cell)

Provider Contact Information

Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Telephone Numbers: ______________________________/__________________/______________________________
(Office) (Fax) (Cell)

Email Address: ____
(Please Print)

Specialty Code

___ AL (Allergy Services)	__ DS (Dental)	___ NE* (ND+DE)	__ PH (Pharmacy)	___ SG (Surgery)
___ AN (Anaesthesiology)	__ GP (General Practitioner)	___ ND (Nutritionist\Dietician)	__ PO (Podiatrist\Chiropodist)	___ SP (MD Specialist)
___ CR (Cardiac)	__ GY (Obstetrics\Gynecology)	___ OC (Occupational Therapist)	__ PS (Psychiatrist)	___ ST (Speech Therapy)
___ DC (Chiropractor)	__ IM (Internal Med. Specialist)	___ OP (Ophthalmology)	__ PT (Physiotherapy)	___ XX (Invalid Provider)
___ DE (Diabetic Edu.)	__ LB (Laboratory)	___ PC (Psychology)	__ RE* (RN+DE)	___ Other __________
___ DI (Diagnostic Imaging)	__ LS (Laser Eye Surgery)	___ PD (Pediatrician)	__ SC (Smoking Cessation)	
PHC Services	__ CG (Caregiver)	___ NA (Geriatric\Nursing Aide)	__ AD (Adult Daycare)	___ RN (Registered Nurse)

*NE is a Nutritionist\Dietician with Diabetic Educator certification. RE is a Registered Nurse with Diabetic Educator certification.

I declare that the information I have given above is accurate to the best of my knowledge.

Signed: ____ Date (dd/mm/yy): ☐☐ / ☐☐ / ☐☐

When completed, this form should be returned with supporting documentation to:
Mailing Address: Health Insurance Department, P.O. Box HM 2160, Hamilton HM JX
Street Address: Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12
Phone: 441-295-9210 **Fax:** 441-295-9213 **Website:** www.hip.gov.bm **Email:** hip@gov.bm

Form: PS01 – Provider Form V07.00
01 September 2015