Provider Profile

Dear Valued Provider,

Kindly fill up this form with the information requested below. Availability of accurate and detailed information about your facility will definitely help QLM staff as well members to deal smoothly with your esteemed organization. Many thanks for your cooperation. (Please fill up this form itself "Don't scan it")

GENERAL DETAILS					
PROVIDER NAME:					
ADDRESS:					
P.O.BOX/ ZIP CODE:		STATE/ PROVINCE:			
CITY:		COUNTRY:			
PHONE:		**FAX:**		**EMAIL:**	
OWNERSHIP:	☐ GOVERNMENT	☐ SEMI GOVERNMENT	☐ PRIVATE		
	☐ OTHERS (PLEASE SPECIFY):				
LICENSE NUMBER:					
AUTHORISED SIGNATORY	NAME:				
	NATIONALITY:				
	PASSPORT NUMBER:				
CONTACT PERSON:					
DESIGNATION:					
PHONE:		FAX:		EMAIL:	

CONTACT DETAILS				
DESIGNATION	**NAME**	**PHONE**	**MOBILE**	**EMAIL**
CEO:				
MEDICAL DIRECTOR:				
FINANCE MANAGER:				
INSURANCE MANAGER:				
INSURACE COORDINATOR:				

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INSURACE COORDINATOR (OP):				
INSURACE COORDINATOR (IP):				
INSURACE COORDINATOR (PHARMACY):				
COLLECTION IN-CHARGE:				

BANK DETAILS	
ACCOUNT NUMBER:	
BRANCH:	
SWIFT CODE:	
IBAN NUMBER:	

DURATION OF ROVIDER PRACTICE

☒ < 1 Year ☐ 1 – 3 Years ☐ 4 – 6 Years ☐ 7 – 9 Years ☐ > 9 Years

QUALITY ASSURANCE PROGRAM

☐ YES ☐ NO

COMMITTEES AVAILABLE

A.		D.	
B.		E.	
C.		F.	

ACCREDITATION

☐ YES	☐ NO	☐ IN PROCESS
☐ JCI	☐ CANADIAN	☐ AUSTRALIAN
☐ OTHERS (PLEASE SPECIFY):		

MEDICAL STAFFING (COUNT)

GENERAL PRACTIONERS:		SUPPORT STAFF:	
SPECIALISTS:		TECHNICIANS:	
CONSULTANTS:		PHARMACISTS:	
NURSING STAFF:		TOTAL PROVIDER STAFF:	

PROVIDER FACILITY	
NUMBER OF OUTPATIENT CLINICS:	
TOTAL HOSPITAL BEDS:	
NUMBER OF ICUS:	

NUMBER OF ICU BEDS:	
NUMBER OF NICU BEDS:	
NUMBER OF INCUBATORS:	
NUMBER OF NURSERY BEDS:	
NUMBER OF EMERGENCY ROOM BEDS:	
NUMBER OF DAY CARE BEDS:	
OPERATION THEATER:	

IF SURGICAL PROCEDURES ARE CONDUCTED OUTSIDE YOUR FACILITY, PLEASE MENTION THE NAME OF THAT FACILITY (HOSPITAL):

EMERGENCY ROOM	☐ YES	☐ NO
DENTAL LABORATORY	☐ YES	☐ NO
INFECTION CONTROL PROGRAM	☐ YES	☐ NO
MEDICAL RECORDS	☐ Physical	☐ Electronic

LABORATORY

BIOCHEMISTRY		MICROBIOLOGY		HEMATOLOGY		HISTOPATHOLOGY		IMMUNOLOGY	
☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO

RADIOLOGY

X-RAY		ULTRASOUND		CT SCAN		DOPPLER		PET SCAN	
☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO

PHARMACY

OUTPATIENT		INPATIENT		SPLIT DUTY		24 HOURS	
☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO

REHABILITATION

PHYSIOTHERAPY		OCCUPATIONAL THERAPY		SPEECH & AUDIOLOGY THERAPY	
☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO

SPECIALITIES AVAILABLE

☐ ALLERGY & IMMUNOLOGY	☐ ANESTHESIOLOGY	☐ CARDIOLOGY
☐ CARDIOVASCULARY SURGERY	☐ DENTISTRY	☐ DERMATOLOGY
☐ EMERGENCY/ TRAUMA MEDICINE	☐ ENDOCRINOLOGY	☐ ENT (EAR, NOSE & THROAT)
☐ GASTROENTEROLOGY	☐ GENERAL/ FAMILY PRACTICE	☐ GENERAL SURGERY
☐ GENETICS	☐ GERONTOLOGY	☐ HAND/ MICRO SURGERY
☐ HEMATOLOGY/ HEMO-DIALYSIS	☐ HEPATOLOGY	☐ INFECTIOUS & TROPICAL DISEASE
☐ INFERTILITY	☐ INTERNAL MEDICINE	☐ MAXILLOFACIAL SURGERY

☐ NEONATAL	☐ NEPHROLOGY	☐ NEUROLOGY
☐ NEUROSURGERY	☐ NUCLEAR MEDICINE	☐ OBSTETRICS & GYNAECOLOGY
☐ ONCOLOGY	☐ OPTHALMOLOGY	☐ ORAL SURGERY
☐ ORTHOPEDICS	☐ PATHOLOGY	☐ PEDIATRICS
☐ PEDIATRIC SURGERY	☐ PLASTIC SURGERY	☐ PNEUMATOLOGY
☐ RADIOLOGY	☐ PSYCHIATRY	☐ RADIOLOGY ONCOLOGY
☐ REHABILITATION MEDICINE	☐ TRANSPLANT SURGERY	☐ UROLOGY
☐ VASCULAR SURGERY	☐ OTHER (PLEASE SPECIFY):	

ANCILLARY SERVICES		
☐ AMBULANCE SERVICES	☐ ARTHROSCOPY	☐ AUDIOLOGY
☐ BRONCHOSCOPY	☐ CARDIAC DIAGNOSTIC CENTER	☐ CARDIAC CATH. LAB
☐ CHEMOTHERAPY	☐ DIAGNOSTIC FACILITY	☐ ENDOSCOPY UNIT
☐ ERCP	☐ HOME HEALTH CARE	☐ IVF UNIT
☐ LITHOTRIPSY	☐ MAMMOGRAPHY	☐ MRI
☐ NERVE CONDUCTION STUDY	☐ OCCUPATIONAL THERAPY	☐ PHYSIOTHERAPY
☐ RADIOACTIVE IMPANT SERVICE	☐ RADIOTHERAPY	☐ SPEECH THERAPY
☐ SUB ACUTE RECOVERY CENTER	☐ TOTAL JOINT REPLACEMENTS	☐ VENTILATORS
☐ BLOOD BANK		

OTHER PROVIDER INFORMATION – PREVIOUS CALENDER YEAR	
NUMBER OF ADMISSIONS PER YEAR:	
AVERAGE BED OCCUPANCY RATE:	
AVERAGE LENGTH OF STAY PER ADMISSION:	
NUMBER OF IN-HOUSE SURGICAL PROCEDURES PER YEAR:	
NUMBER OF TOTAL BIRTHS PER YEAR:	
NUMBER OF BIRTHS (C-SECTION) PER YEAR:	
NEONATAL DEATHS (> 1000g BIRTH WEIGHT) PER YEAR:	
NASOCOMIAL INFECTION RATE %:	
UNSCHEDULE RETURNS TO ICU:	
SURGICAL INFECTION RATE %:	
TOTAL NUMBER OF READMISSIONS (WITHIN 30 DAYS OF PRIOIR ADMISSION):	
AVERAGE OUTPATIENT VISIT COST	

CREDENTIALS TO BE ENCLOSED	
DOCUMENTS	**ENCLOSED**
Institution License Copy by Ministry of Health	☐
Commercial Registration Copy	☐
Proof of Signatory Authority "Company ID Card" (which carries authorized signatories)	☐
License copy of the practitioners by Ministry of Health	☐
Passport /Local ID Copy of the authorized signatory	☐
Blank Letter Head	☐
Provider Tariff with Discount Structure (in excel format)	☐
List of Doctors (in excel sheet as per the below template)	☐

DOCTOR NAME	SPECIALITY	QUALIFICATIONS	LICENSE TYPE	CONTACT NO.

PROVIDER COMMENTS:

FOR QLM USE ONLY

COMMENTS:

NETWORK CATEGORIZATION

☐ EMERALD ☐ PEARL ☐ QUARTZ

The above information is true to best of our information.

Name:

Designation:

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