Medical Service Provider Application Form

Please return this form with a price list to:
Seven Corners, Inc. – Attention: SCIPN – 303 Congressional Boulevard, Carmel, Indiana 46032 USA
Fax +1.317.815.5984 – **Email** international.network@sevencorners.com

PROVIDER INFORMATION

Provider Name: _____
Physical Address: _____ P.O. Box: _____
City: _____ Postal Code: _____
Country: _____ Web URL: _____
Telephone: _____ Fax: _____
VAT/Tax ID: _____ License/Registration ID: _____

Please provide a copy of relevant certificates where available.

Member of Hospital Group? YES ☐ NO ☐
If YES, please provide the name of group: _____

Additional Locations? YES ☐ NO ☐
If YES, please provide contact details below. You may attach a separate sheet if necessary.

Name: _____
Address: _____
City: _____ Country: _____
Phone: _____
Fax: _____

Name: _____
Address: _____
City: _____ Country: _____
Phone: _____
Fax: _____

KEY CONTACTS

Hospital Administrator
Name: _____
Phone: _____
Fax: _____
Email: _____

Medical Director
Name: _____
Phone: _____
Fax: _____
Email: _____

Admissions Department
Name: _____
Phone: _____
Fax: _____
Email: _____

Emergency Department
Name: _____
Phone: _____
Fax: _____
Email: _____

Patient Accounts / Credit Control
Name: _____
Phone: _____
Fax: _____
Email: _____

Insurance Department / Agreements
Name: _____
Phone: _____
Fax: _____
Email: _____

FACILITY STATISTICS

Total number of beds		Number of Intensive Care beds	
Number of Neonatal Intensive Care beds		Number of private rooms	
Number of semi-private rooms		Number of shared rooms	
24/7 Emergency Department		24/7 on-site doctor led resuscitation	
Average doctor to patient ratio		Average nurse to patient ratio	
Number of admissions per year		Number of emergency visits per year	
Number of day cases per year		Number of international patients per year	
International Patient Centre on-site		Ambulance Service available	
English spoken by medical staff		English spoken by administrative staff	

LIST OF SPECIALTIES *(PLEASE CHECK ALL THAT APPLY)*

☐ ACCUPUNCTURE	☐ HYPERBARIC MEDICINE	☐ PEDIATRICS
☐ ALLERGY/IMMUNOLOGY	☐ IMAGING	☐ PEDIATRIC SURGERY
☐ ALTERNATIVE MEDICINE	☐ INFECTIOUS DISEASES	☐ PHARMACY
☐ ANESTHESIOLOGY	☐ INTENSIVE/CRITICAL CARE	☐ PHYSIOTHERAPY
☐ AUDIOLOGY	☐ INTERNAL MEDICINE	☐ PLASTIC SURGERY
☐ BRAIN INJURY MEDICINE	☐ LABORATORY	☐ PODIATRY
☐ BURN CENTRE	☐ MAXILLOFACIAL SURGERY	☐ PREVENTATIVE MEDICINE
☐ CARDIOLOGY	☐ MEN'S HEALTH	☐ PROCTOLOGY
☐ CARDIOTHORACIC SURGERY	☐ MIDWIFE	☐ PSYCHIATRY
☐ CARDIO ELECTROPHYSIOLOGY	☐ NEONATOLOGY	☐ PSYCHOLOGY
☐ CHIROPRACTOR	☐ NEPHROLOGY	☐ PULMONOLOGY
☐ DENTISTRY	☐ NEUROLOGY	☐ RADIOLOGY
☐ DERMATOLOGY	☐ NEUROSURGERY	☐ RADITION THERAPY
☐ DIALYSIS-OUTPATIENT	☐ NUCLEAR MEDICINE	☐ REHABILITATION
☐ DIALYSIS-INPATIENT	☐ NUTRITION/DIETETICS	☐ REPRODUCTIVE MEDICINE
☐ EAR, NOSE & THROAT	☐ OBSTETRICS/GYNECOLOGY	☐ RHEUMATOLOGY
☐ EMERGENCY MEDICINE	☐ OCCUPATIONAL THERAPY	☐ SLEEP MEDICINE
☐ ENDOCRINOLOGY	☐ ONCOLOGY	☐ SPEECH THERAPY
☐ FAMILY MEDICINE	☐ OPHTALMOLOGY	☐ SPINAL SURGERY
☐ GASTROENTEROLOGY	☐ OPTOMETRY	☐ SPORTS MEDICINE
☐ GENERAL PRACTITIONER	☐ ORGAN TRANSPLANT SURGERY	☐ SUBSTANCE ABUSE
☐ GENERAL SURGERY	☐ ORTHODONTICS	☐ TRAUMATOLOGY
☐ GENETICIST	☐ ORTHOPAEDICS	☐ TROPICAL DISEASES
☐ GERIATRIC MEDICINE	☐ PAIN MEDICINE	☐ UROLOGY
☐ HEMATOLOGY	☐ PALLIATIVE CARE	☐ VASCULAR SURGERY
☐ HEPATOLOGY	☐ PATHOLOGY	☐ OTHER: _____

EQUIPMENT / SERVICES *(PLEASE CHECK ALL THAT APPLY)*

Cardiology:

☐ ANGIOPLASTY/STENT	☐ ANGIOGRAPHY	☐ CATHETERIZATION
☐ DEFIBRILLATOR/MONITOR	☐ ECG/EKG	☐ ECHO
☐ ETT/STRESS TEST	☐ HOLTER MONITOR	☐ OTHER:_____

Gastroenterology:

☐ ERCP	☐ LOWER GI ENDOSCOPY	☐ UPPER GI ENDOSCOPY
☐ SIGMODOSCOPY	☐ OTHER: _____	

Nephrology/Urology:

☐ CYSTOSCOPY	☐ HEMODIALYSIS - INPATIENT	☐ HEMODIALYSIS - OUTPATIENT
☐ LITHOTRIPSY	☐ PERITONEAL DIALYSIS	☐ RENAL ENDOSCOPY
☐ URETEROSCOPE	☐ OTHER: _____	

Neurology:

☐ EEG	☐ EMG	☐ ENG
☐ MEG	☐ OTHER: _____	

Laboratory:

☐ BIOCHEMISTRY	☐ BLOOD BANK	☐ BLOOD GASES
☐ CYTOPATHOLOGY	☐ GENETICS	☐ HEMATOLOGY/CBC
☐ HISTOPATHOLOGY	☐ IMMUNOLOGY/SEROLOGY	☐ MICROBIOLOGY
☐ PARASITOLOGY	☐ SURGICAL PATHOLOGY	☐ TOXICOLOGY
☐ URINALYSIS	☐ VIROLOGY	☐ OTHER: _____

Pulmonology:

☐ BRONCHOSCOPY	☐ SPIROMETRY	☐ V/Q LUNG SCAN
☐ VENTILATORS	NUMBER OF VENTILATORS:____	☐ OTHER: _____

Radiology:

☐ CT SCAN	☐ FLUOROSCOPY	☐ MAMMOGRAPHY
☐ MRI SCAN	☐ PET SCAN	☐ ULTRASOUND
☐ X-RAY	☐ OTHER: _____	

Transportation:

☐ AMBULANCE	☐ HELICOPTER	☐ OTHER: _____

Vaccinations:

☐ CHOLERA	☐ DPT	☐ HEPATITIS A
☐ HEPATITIS B	☐ HIB	☐ HPV
☐ INFLUENZA	☐ JAPANESE ENCEPHALITIS	☐ MENINGOCOCCAL
☐ MMR / MMRV	☐ POLIO	☐ RABIES
☐ SMALLPOX	☐ TUBERCULOSIS	☐ TYPHOID
☐ VARICELLA	☐ YELLOW FEVER	☐ OTHER: _____

COMPLIMENTARY INFORMATION

What is the legal entity type of the hospital? PRIVATE ☑ PUBLIC ☐ OTHER ☐
If OTHER, please specify: _____

What is the ownership type of the hospital? INDIVIDUAL ☐ PARTNERSHIP ☐ OTHER ☐
If OTHER, please specify: _____

Please confirm that all clinical staff hold appropriate registration/licenses: YES ☐ NO ☐

Other languages spoken by hospital staff: _____

Does the hospital have affiliations or training arrangements with any universities? YES ☐ NO ☐
If YES, please specify: _____

Does the hospital have affiliations with other hospitals on a national/international basis? YES ☐ NO ☐
If YES, please specify: _____

Does the hospital have agreements with international insurance companies? YES ☐ NO ☐
If YES, please specify: _____

Is the hospital considered as a centre of excellence for specific diagnoses or treatments? YES ☐ NO ☐
If YES, please specify: _____

Status of doctors *(Please send us a list of doctors working in the hospital)* INDEPENDENT ☐ PAYROLL ☐

CLINICAL QUALITY ACCREDITATIONS

International *(e.g. JCI)* YES ☐ NO ☐ APPLYING ☐
Name of accreditation: _____

National YES ☐ NO ☐ APPLYING ☐
Name of accreditation: _____

Please provide a copy of the certificates if you answered yes to either of the above questions.
You may attach a separate sheet to provide further accreditation details if necessary.

Have the doctors received post-graduate medical training in U.S./European (western) medicine at an internationally accredited hospital or medical center? YES ☐ NO ☐
If YES, please specify: _____

PRICING, CODING AND DISCOUNTS

** Please send us a copy of your current price list/rates with this completed form. **

Is the facility able to offer any discounted rates? *(please specify)* _____

_____

_____

Coding Services:	ICD-9	YES ☐	NO ☐
	ICD-10	YES ☐	NO ☐

Other (please specify):_____

Printed Name: _____ Title: _____

Signature: _____ Date: _____

SUPPORTING DOCUMENTS CHECKLIST:

- ☐ Price list/rates
- ☐ Copies of licenses/certifications *(where applicable)*
- ☐ Copies of accreditation certificates *(where applicable)*
- ☐ List of doctors practicing at facility *(where applicable)*
- ☐ Curriculum vitae *(private practice physician applicants only)*