مجلس الضمان الصحي التعاوني
Council of Cooperative Health Insurance

Cooperative Health Insurance Fund Program Application

General Information

Health Provider Name: **Accreditation No#**

Representative Name: **Contact No#**

Region: **E-mail:**

National Address

Building No# Street name: Neighborhood name:

City: Zip code# Alternate phone#

Agreement

In reference to the Council's General Secretariat launching the Cooperative Health Insurance Fund program for the purpose of covering medical cases for those who exceeded the upper limit of the unified policy for the insured, so the Council seeks to establish a Preferred Providers Network (PPN) from health service providers, especially for the Fund, so I hope you will inform us of your desire to Join:

☐ **Yes** **Additional discount rate offered to the fund:**

☐ **No**

Obligation

I agree to adhere by the Council's legislations and regulations and to obey the special requirements of the fund , such as complying with the requirements of the National Platform for Healthcare Information Exchange Services (NPHIES), and to submit health claims to the Fund through NPHIES, complying with the minimum data requirements (MDS) and the price list of the Council, and using the system Saudi Billing (SBS).

Acknowledgment

Name: **Date:**

Position: **Signature:**