

## THE NATIONAL HEALTH INSURANCE MANAGEMENT AUTHORITY

FORM VI  
(Regulation 11 (1))The National Health Insurance Act, 2018  
(Act No. 2 of 2018)

## The National Health Insurance (General) Regulations, 2019

## APPLICATION FOR ACCREDITATION AS HEALTH CARE PROVIDER

<b>INSTRUCTIONS</b>		
1. Complete this form in one (1) copy.		
2. Complete the applicable portions only.		
3. Type or print all entries in BLOCK/CAPITAL LETTERS.		
4. This form shall be submitted online or to the Head Office of the National Health Insurance Management Authority.		
<b>REQUIREMENTS</b>		
Health Professions Council of Zambia registration No.		
<b>A. NAME OF HEALTH CARE PROVIDER</b>		
<b>B. LOCATION (Plot Number, street name, town and province)</b>		
<b>C. POSTAL ADDRESS</b>		
<b>Tel No. 1</b>	<b>Tel No. 2</b>	<b>Tel No. 3</b>
<b>Fax:</b>		<b>Email:</b>
<b>Town:</b>	<b>District:</b>	<b>Province:</b>
<b>D. NAME OF CHIEF EXECUTIVE/ADMINISTRATOR/PROPRIETOR:</b>		
<input type="checkbox"/> Prof. <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		
<b>Type of Application:</b>		
1. Initial <input type="checkbox"/> 2. Re-accreditation <input type="checkbox"/>		
If application is for re-accreditation, when was your accreditation revoked: .....		
<b>1. INITIAL ACCREDITATION OF HEALTH CARE PROVIDER</b>		
<b>Level Applied For:</b>		
1.1 <input type="checkbox"/> Hospital	1.1 <input type="checkbox"/> Doctors	
1.2 <input type="checkbox"/> Hospice	1.2 <input type="checkbox"/> Nurses	
1.3 <input type="checkbox"/> Clinic	1.3 <input type="checkbox"/> Dentists	
1.4 <input type="checkbox"/> Laboratory	1.4 <input type="checkbox"/> Pharmacists	
1.5 <input type="checkbox"/> Diagnostic Centre		
1.6 <input type="checkbox"/> Pharmacy		
1.7 <input type="checkbox"/> Ambulance Service		

2. CERTIFICATION BY APPLICANT	
I CERTIFY THAT THE INFORMATION AND ALL STATEMENTS PROVIDED ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.	SIGNATURE OF APPLICANT: ..... DATE: (dd/mm/yy) ...../...../.....
FOR OFFICIAL USE	
DOCUMENT SUBMITTED WHERE APPLICABLE:	APPROVED <input type="checkbox"/> NOT APPROVED <input type="checkbox"/>
1. <input type="checkbox"/> copy of certificate of incorporation of registration of business name	SIGNATURE: .....
2. <input type="checkbox"/> Proof of accreditation with other relevant authority (e.g HPCZ) other (please specify) .....	DATE: (dd/mm/yy) ...../...../.....
3. <input type="checkbox"/> valid licence to provide services (e.g HPCZ) from other relevant authority	REASONS FOR NOT APPROVING:
4. <input type="checkbox"/> Other (please specify)	a. .... b. .... c. .... d. ....
Note: * HPCZ- Health Professions Council of Zambia	