



Healthcare Proposal Application

Office Use Only	
Ref #:	_____
Last Ref #:	_____

Business Information

Business Name: _____

Physical Address: _____

Mailing Address: _____

Business Tel #: _____ **Business Fax #:** _____

List your core Business Products/Services.

How long have you been in business? _____

Name the other Bermuda businesses that supply the service you plan to offer.

Contact Information

Contact Name/Title: _____

Contact Phone/Ext: _____

Contact Email: _____

Employed Health Professionals

Name of employed health professional:	Supporting credentials for proposal (e.g. membership to professional body):
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Health Proposal Summary

Proposal Title:	Start Date:
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Proposal Objectives:

Proposal Description:

How will your product/service benefit the Bermuda community?

What segment of the Bermuda community are you targeting?

What will be the negative impact to the Bermuda community if your proposal is not accepted?

Medical Opinion

List health risks.

Health Proposal Statistics

Historical Volumes (3-5 years):

Future Volumes (3-5 years):

Health Proposal Funding

CPT code:	_____	CPT fee:	_____	Proposed fee:	_____
CPT code:	_____	CPT fee:	_____	Proposed fee:	_____
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CPT code:	_____	CPT fee:	_____	Proposed fee:	_____
CPT code:	_____	CPT fee:	_____	Proposed fee:	_____

Name: _____ Title: _____
Signature: _____ Date: _____