**Affiliation Declaration Form**

1. **Provider Details and Particulars:**

|  |  |
| --- | --- |
| Application Reference Number *(to be filled by Daman)* |  |
| Application Type *(to be filled by Daman)* |  |
| **Company Information** | |
| Main provider code (for Branch Addition only) |  |
| Provider Name (as per Trade License) |  |
| Provider Type |  |
| General Manager |  |
| Financial Manager |  |
| DOH Facility License Number |  |
| Trade License Number |  |
| Medical Facility License Expiry Date |  |
| **Contact Information** | |
| Address/Location with GPS Coordinates |  |
| Emirate |  |
| City |  |
| Telephone Number |  |
| Fax Number |  |
| Direct Contact Person |  |
| E-Mail |  |
| Mobile Number |  |
| P.O Box |  |
| **Speciality and Other Information** | |
| Available License Speciality with License Numbers |  |

1. **Affiliated Healthcare Facility Declaration:**

This section requires you to disclose if you (the applying provider) has any affiliation to an existing healthcare facility in the United Arab Emirates, whether such affiliated healthcare facility is/is not part of Daman’s network.

1. **Affiliation Declaration:**

**Affiliation shall be as per the following criteria:**

* Ownership interest that an individual or entity has in another healthcare facility, regardless of the ownership percentage;
* Having managerial or operational control, or directly or indirectly controlling the day-to-day operations of another healthcare facility;
* Acting in the capacity as a director or manager of another healthcare facility;
* If a 3rd party will be involved directly/indirectly in claims processing/ handling contractual changes/management of the facility, or in any other manner that can affect the contractual relationship

Please provide the required information set out in the table below, with respect to any medical facility with whom you are affiliated to (if applicable):

☐We, the applying facility hereby declare that we have an affiliation to another healthcare facility (as per the details set out below).

☐We, the applying facility hereby declare that we have no affiliation to another healthcare facility. List down all affiliated healthcare facility(ies):

|  |  |  |
| --- | --- | --- |
| **Name of Applying Provider** | **Name of Affiliated Healthcare Facility** | **Relationship existing between applying provider and affiliated healthcare facilities** |
|  |  |  |
|  |  |  |

1. **Owners and Partners Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Owners/Partner Names** | **Emirates ID Number /Passport Number (if no EID is available)** | **Affiliated to other healthcare facilities**  **(Yes/No)** | **If Yes, please attach the Trade License Copy** | **Name of Affiliated Healthcare Facility** |
|  |  |  |  |  |
|  |  |  |  |  |

1. **Real Beneficiary Record:**

|  |  |  |
| --- | --- | --- |
| **Real Beneficial Owner** | | |
| Name |  | |
| **Board of Directors Members** | | |
| Name |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
| **Beneficial Amendment Information** | | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
| **Beneficial Issue Information** | | |
| Manager name | |  |
| EID number | |  |
| Unified number | |  |
| Passport number | |  |
| Nationality | |  |
| Email address | |  |
| Phone number | |  |
| Address | |  |
| Home Country ID number | |  |
| Issuance Country | |  |

1. **Disclosable Events:**

Please list down disclosable events such as but not limited to the below list related to the listed affiliated healthcare facilities, partners and owners:

* Daman Medical and Investigation Audit Department feedback, ongoing audit, open cases, improper billing and overpayment, etc. since the effective date of the Standard Provider Contract (SPC).
* Medical cost and optimization findings (over utilization, physician’s termination, warning letters, etc) as issued by Daman.
* Previously terminated from Daman’s provider network.
* Court cases regardless of the current status and of whether Daman is the claimant or defendant in such proceedings.
* Cancellation or temporary suspension by the Department of Health regardless of the reason related to such cancellation or temporary suspension.
* Identified performance and quality issues by the Department of Health or Daman.

|  |  |
| --- | --- |
| **Name of Affiliated Healthcare Facility/Partner/Owner** | **Findings/Disclosable Event** |
|  |  |
|  |  |

☐We, the applying facility hereby, declare that the above-mentioned information is correct and true.

☐We, the applying facility hereby acknowledge that providing any incorrect or false information may result in legal or disciplinary action being taken against me and the applying facility, if discovered at any time. Daman shall have the right to terminate the contract immediately in the event that it discovers that any of the provided information set out in this form is untrue and/or false and shall have the right to recover any dues which have been paid to the applicant facility due to such misrepresentation.

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**Complete Name and Signature of Authorized Signatory**

**with Official Facility Stamp**

*Please attach a copy of the Emirates ID of the Authorized Signatory along with a valid Power of Attorney upon submitting this form*

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_