مجلس الضمان الصحي
Council of Health Insurance

PAYMENT NOTICE FORM

instructions

* The transfer or deposit receipt through e-services must be attached to the CHI website.

* In case of direct transfer/deposit, use the following account: IBAN NO. SA 381 000 002 220 0000 333 601 (SNB_Saudi National Bank)

Date: / /20 .

Facility Data:

Facility Type: ☐ Insurance Company ☐ TPA Company ☐ Health Care Provider_Facility Type(_____)

☐ Other customers: _____

Facility name: _____ Register No. in the CHI: (_____)

☐ New subscription.

Payment Details:

Payment type: ☐ direct deposit ☐ transfer

Remitter account number_____ at the bank _____ Deposit |transfer date: __/ __/20__.

Reference number: _____ Remitter Name| or depositor. _____

paid amount: in numbers ( ) SR and in written: _____SR

Subscription type:

☐ Qualification of an insurance company/ (new)TPA company ☐ Requalification of an insurance company/TPA company/ ☐ The financial return for supervising insurance companies/TPA company

☐Accreditation as a health care provider (new). ☐ Renewal of accreditation

☐Payment of financial fees for qualification/accreditation. ☐ Other (specify): .....

Facility contact Information

Name: ..... Job Title: .....

Phone..... Mobile: .....

Fax: ..... E-mail: .....