pcns
practice code numbering system
a division of BHF

BOARD of HEALTHCARE FUNDERS of SOUTHERN AFRICA
(Association Incorporated under Section 21 Registration number 2001/003387/08)

37 Bath Avenue
Rosebank 2196
PO Box 2324
Parklands 2121
Johannesburg
South Africa

Tel: +27 11 537-0200
Fax: +27 11 880-5959 / 086 607 3703
e.mail: clientservices@bhfglobal.com
Client Services: 0861 30 20 10
www.bhfglobal.com

Application form for a Practice Number for SANC Registered Nurses

PLEASE NOTE THAT FAXED APPLICATIONS ARE NOT ACCEPTED

A practice number is allocated based on the authority granted to the BHF by the Council for Medical Schemes to allocate practice numbers to suppliers of relevant healthcare services.

The BHF's PCNS division ("PCNS") is the entity tasked with the administration of practice code numbers.

The PCNS allocates practice code numbers to suppliers of relevant health services who comply with the PCNS application verification criteria.

In accordance with legislation and BHF policies, a practice number may not be issued without the following:

- **Certified** copy of ID.
- **Certified** copy of the passport, where the applicant is not a South African citizen.
- **Certified** copy of marriage certificate, where the name on the registration certificate differs to that on the identity document.
- **Certified** copy of a registration certificate from the South African Nursing Council.
- Proof from the South African Nursing Council that the subscription fee has been paid for the current year.
- If you are an employee of a Provincial Hospital, please forward documentation confirming that you have the necessary permission to practice outside of your conditions of employment with the state.
- **Please complete the following forms which are attached hereto.**
  - **Form providing details of a Commissioner of Oaths.**
  - **Form providing details of the facility/service/business.**
  - **Signed declaration.**
  - **Banking details verification form.**
  - **The bank debit order instruction form (optional) for PCNS annual renewal fees.**

Should you have any queries regarding this application, please contact Client Services on **0861-30-20-10**, by facsimile on **(011) 880-5959** or **086-607-3703**, or e-mail clientservices@bhfglobal.com

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Applications will NOT be processed without ORIGINAL DOCUMENTATION OR COPIES CERTIFIED by one of the South African registered authorities listed below. The stamp on the certified document must include the name of the Commissioner of Oaths and the words COMMISSIONER OF OATHS. Please note that the BHF policy requires that in order to obtain a practice number, a health service provider must be registered in terms of South African Law, as this is a requirement of the Medical Schemes Act (Act. No 131 of 1998).

* Advocate * Attorney * Notary * Conveyancer * Bank Manager *Judge * Clerk of the Court * Magistrate * Police

DETAILS OF COMMISSIONER OF OATHS:

Full Name & Surname _____

Reference number _____

Signature _____

Postal address _____ **Physical address** _____

_____ _____

_____ _____

Code _____ **Code** _____

Town _____ **Town** _____

Contact number _____

Fax number _____

E-mail _____

COMMISSIONER OF OATHS STAMP

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PERSONAL DETAILS

Title _____ Initials _____ First Names _____ Surname _____

ID Number _____ Council Number _____

PRACTICE DETAILS

Please note that requests to backdate or alter the original starting date cannot be accommodated

Effective starting date of practice number_____ VAT number _____

Discipline _____ Sub-Discipline (If applicable) _____

Dispensing Licence | Yes | No | Licence number *(If applicable)* _____ Effective date _____

Practice Postal Address _____
_____
_____
Code_____Province_____
Telephone Number (_____) _____
Facsimile Number (_____) _____

Practice Physical Address_____
_____
_____
Code _____Province_____
Cell Number (_____) _____
E-mail Address_____

EDI DETAILS

(Only applicable where claims for reimbursement are submitted electronically)

EDI User	Yes	No	EDI Company

Would you prefer that medical schemes reimburse you by making a direct payment into your bank account	Yes	No

BANK DETAILS

We would like to bring to your attention that it is an obligation of medical scheme administrators to verify healthcare providers' banking details. However, since the banking details of providers of service form part of the data set contained within the PCN system, BHF will continue updating this information disseminating them to medical schemes..
Providers of service are therefore advised to contact medical schemes with which they do business in order to verify their banking details.

Please ensure that the form is endorsed by the relevant bank by obtaining a bank stamp on the bottom left hand corner
OR
Submit an original cancelled cheque/ Original letter from the bank confirming banking details

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Banking Details Verification Form

To: BHF Client Services

I/ We declare that the details on this Banking Verification Form are correct and may be used by the medical schemes and their administrators for reimbursement of claims.

I/ We authorise medical schemes and their administrators to pay any amounts which accrue to me / us to the credit of my / our account into the below mentioned bank account.

Service Providers are requested to complete and submit this form via registered mail to:
BHF Client Services, PO Box 2324, Parklands, 2121.

Please ensure that the form is endorsed by the relevant bank by obtaining a bank stamp on the bottom left corner.

Practice Name	
Name of Bank	
Name of Branch	
Account Name	
Branch Code	
Account Number	
Type of Account	Current / Savings / Transmission
New Account	Yes / No

If yes, state date on which account became effective (dd/mm/yyyy)

Provider's Initials & Surname	**Authorised Signature**

Bank account particulars certified as correct			
YES	**NO**	**Name of Bank Official**	**Signature Of Bank Official**

BANK STAMP

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Declaration

I, the undersigned, hereby declare that the information contained on the application form is valid and correct and duly authorise the PCNS Division of the Board of Healthcare Funders of Southern Africa (BHF) to disseminate this information for reimbursement purposes only.

I undertake to advise the Practice Code Numbering System Division of any changes to my practice profile in the event that such changes may occur.

I further declare that I will abide by the following:

I agree to pay an annual fee as determined by BHF towards the maintenance and running of the PCNS for the period that my practice number remains active. I acknowledge that failure to renew registration on an annual basis and to pay the annual registration fee will result in my practice number being rendered inactive.

I agree to comply with all relevant legislation. In terms of regulation 5(f) of the Medical Schemes Act (Act 131 of 1998), it is a requirement that all registered providers of healthcare services include diagnostic codes on accounts or statements that may be used to claim benefits from medical schemes and administrators. I declare that I will comply with the requirement of regulation 5(f) of the General Regulations to the Medical Schemes Act and will use the ICD 10 Code for this purpose. In terms of regulation 5(h) of the Medical Schemes Act (Act 131 of 1998), it is a requirement that all registered providers of healthcare include the full cost on accounts or statements that may be used to claim benefits from medical schemes and administrators. I declare that I will comply with the requirement of regulation 5(h) of the General Regulations to the Medical Schemes Act requiring the full cost of rendering a service to be included on all accounts or statements.

I declare that I am registered with the relevant South African statutory body.

I agree to comply with all obligations in terms of the Income Tax Act.

I acknowledge that a practice number does not guarantee payment by a medical scheme or medical scheme administrator.

I hereby agree and acknowledge that details with regards to fraudulent activities associated with the practice number allocated in consequence of this application will be made available to the Board of Healthcare Funders' Forensic Management Unit.

_____ _____

SIGNATURE OF APPLICANT **DATE**

_____

FULL NAME AND SURNAME OF SIGNATORY

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PCNS Registration Fees

- **2012 Registration fee – R115.00 incl. VAT**

Applications will not be processed without proof of payment of PCNS registration fees.
For security reasons, we prefer not to have cash on the premises. We therefore request that you make use of one of the payment methods listed below:

Cheque Payment

Registration fee payable to: **PCNS**
Address to which cheque must be sent: **P O Box 2324**
Parklands
2121

OR

Direct Deposit

Bank	:	**Nedbank**
Branch	:	**The Mall of Rosebank**
Branch code	:	**197705**
Account No	:	**1958 518 530**
Account Type	:	**Cheque account**
Account Name	:	**PCNS**

(PLEASE USE YOUR SURNAME AND COUNCIL REGISTRATION NUMBER AS A REFERENCE. PLEASE ATTACH THE PROOF OF PAYMENT TO YOUR APPLICATION FORM)

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BANK DEBIT ORDER INSTRUCTION

Please complete and fax to 086-607-3988 or e-mail eunicag@bhfglobal.com
Please note that incomplete forms will not be accepted.

Provider details

DATE: _____

SERVICE PROVIDER NAME: _____

PRACTICE NUMBER: _____

BUSINESS PHYSICAL ADDRESS: _____

_____

_____

Bank details for debit order transaction purposes only

The details of my/our account are as follows:

BANK: _____

BRANCH NAME: _____

BRANCH CODE: _____

ACCOUNT NAME: _____

ACCOUNT NUMBER: _____

ACCOUNT TYPE: _____

In the case of an incorporated practice or a group practice, please ensure that the signatures of all the partners are also reflected below.

Initial & Surname	Authorised Signature
Initial & Surname	Authorised Signature
Initial & Surname	Authorised Signature
Initial & Surname	Authorised Signature

DIRECTORS
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ZH Zokufa (Managing)
Non-Executive
CM Mini (Chairman)
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I/We hereby request and authorise BHF to debit my/our account with the annual fee on either of the following (please select applicable date):
February: 15 / 28; ***March***: 15 / 31

This authority may be cancelled by means of giving you 30 days notice in writing, sent by prepaid registered post. I/We understand that I/we shall not be entitled to refunds of amounts, which you have withdrawn whilst this authority was in force while such amounts were legally owing to you.

I/We acknowledge that the party hereby authorised to effect the drawing against my/our account may not cede or assign its rights and that I/we may not delegate any of my/our obligations in terms of this contract/authority to any third party prior to written consent of the authorised party.

Signed at: _____ on this _____ day of _____20_____.

SIGNATURE AS USED FOR SIGNING MY/OUR CHEQUES ON THE LINE BELOW:

_____

DIRECTORS
Executive
ZH Zokufa (Managing)
Non-Executive
CM Mini (Chairman)
A Meyer (Deputy Chairman)
GR Anderson
E Chitekedza (Zimbabwe)
M Dawson BM Dick
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