

Application form for a Practice Number for a Primary Drug Care Therapist

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 the owner(s) ID
- ***Certified*** copy of the passport, where the applicant is not a South African citizen.
- ***Proof*** of Registration with the Pharmacy Council.
- ***Certified*** copy of the Closed Corporation (cc), Propriety Limited Pty (LTD), Incorporation Company or Non for Profit Organisation registration certificate from the Registrar of Companies (where applicable).
- ***Certified*** copy of Section 22A(15) permit from the Department of Health South Africa.
- **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

Undesirable Business Practices

Healthcare practitioners registered with the HPCSA, applying for a practice number should take note of the HPCSA policy document on Undesirable Business Practices on "Employment of Practitioners".

To access the full policy document, utilise the link below:

http://www.hpcsa.co.za/downloads/conduct_ethics/undesirable_business_practices.pdf

DIRECTORS

Executive

ZH Zokufa (Managing)

Non-Executive

CM Mini (Chairman)

A Meyer (Deputy Chairman)

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E Chitekedza (Zimbabwe)

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L Mc Donald

G U Mbapaha (Namibia)

GS Newton

MNS Ramokgopa

DLC Pienaar JJ Pretorius

SJ Velzeboer (Australia)



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

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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OWNERS DETAILS

Title _____ Initials _____ First Names _____ Surname _____
ID Number _____ Council Number _____

PRIMARY DRUG CARE THERAPIST DETAILS

(please note that the practice number will be registered in the company's name indicated on this form)

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

Company Name _____
Effective start date of practice _____ Vat Number _____
Discipline _____ Sub-Discipline (if applicable) _____

Proprietary Limited	Yes	No		Yes	No
Closed Corporation	Yes	No		Yes	No
Incorporated Company	Yes	No		Yes	No

Company registration (if applicable)

Practice Postal Address _____ Practice Physical Address _____
Code _____ Province _____ Code _____ Province _____
Telephone Number (_____) _____ Cell Number (_____) _____
Facsimile 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 and 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 detail



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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)										
Initial & Surname	Authorised Signature									
Initial & Surname	Authorised Signature									
Initial & Surname	Authorised Signature									
Initial & Surname	Authorised Signature									
Initial & Surname	Authorised Signature									
Initial & Surname	Authorised Signature									
Banking Details Certified as Correct		Name and Signature of Bank Official				Bank Stamp				
YES	NO									

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

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: _____

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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



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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:

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