


Banking Details Verification Form


Please Note


Please show by ticking the below that you have read and understood the information :

1	The completed update form can be sent to pcns_admin@bhfglobal.com	<input type="checkbox"/>
2	<p>As part of the update process, PCNS is required to verify the state employ of each applicant through the DPSA search: https://www.dpsa.gov.za/resource_centre/psverification/). To ensure that your update is processed timeously please ensure that the necessary approvals in the form of the below listed have been submitted together with your update form.</p> <ul style="list-style-type: none"> • Confirmation of Community of Service Completion • Resignation letter • RWOPS Approval Certificate • RWOPS Application form. NB: The RWOPS Application form should be stamped, dated, and signed by both the employer and designated authority and should have exceeded the 30-day submission period with your state employer • Sessional Work Contract. <p>Please also supply the contact details of the persons responsible to confirm the approval/resignation.</p> <p>Once your approval (Confirmation of the end of Community Service/ Resignation letter/RWOPS Approval Certificate/RWOPS Application Form /Sessional Work Contract) has been received we are going to perform a validation with your employer. We will contact the employer at the state facility via email and telephone to verify that approval has been granted for remunerative work outside the public service or if the nature of your employment allows for private practice. Thus, we urge you to provide the correct contact information for the employer on the update form to ensure the process is not delayed. We also encourage you to advise your employer that the validation will take place, so they are aware</p>	<input type="checkbox"/>
3	All Healthcare Service Providers who are in Public Service are required to submit the renewed necessary approvals stipulated above annually to avoid the suspension of their practice numbers.	<input type="checkbox"/>
4	The Compliance and Risk Unit has been established to monitor adherence to the PCN System's Terms and Conditions.	<input type="checkbox"/>
5	Should you have any Queries regarding this Application, please contact Client Services at +27 87 210 0500 or e-mail clientservices@bhfglobal.com	<input type="checkbox"/>

KINDLY NOTE THIS UPDATE FORM MUST BE FULLY COMPLETED IN ADDITION TO THE SUPPORTING DOCUMENTATION REQUIRED TO BE SUBMITTED. FAILURE TO DO SO WILL RESULT IN THE DELAY IN THE PROCESSING OF UPDATING YOUR ACCOUNT.

 Lower Ground Floor, South Tower
1Sixty Jan Smuts, Rosebank, 2196

 P O Box 2863, Saxonwold, 2132
clientservices@bhfglobal.com

 T 087 210 0500

DIRECTORS NJ Khauoe (Chairperson) • G Goolab (Deputy Chairperson) • JK Mothudi (Managing Director) • GA Bartlett • BC Kamanga (Malawi) • NPB Khumalo • JH Joubert • SM Mkhonta (eSwatini) • TM Mloyi-Ncube (Zimbabwe) • CM Mokgosana (Botswana) • BOS Moloabi • FM Mosoeu • MS Mphomela • RR Nandkoomar • FV Nompumza • HC Schäfer (Namibia) • MC Wilson

Please show by ticking the below that you have read and understood the information: ☐

SUPPORTING DOCUMENT CERTIFICATION

Applications WILL NOT BE PROCESSED WITHOUT CERTIFIED COPIES OF ORIGINAL DOCUMENTATION by a South African registered Commissioner of Oaths authority. **The commissioner of oaths should be impartial, unbiased, not related to the Healthcare Service Provider (HSP), and who has no interest in the HSP (such as any immediate family members of the HSP, any employee or employer of the HSP, or any colleague of the HSP).** The stamp on the certified document must be dated, including the name of the Commissioner of Oaths and the words COMMISSIONER OF OATHS, and valid for 6 months from the date of certification. Please note that the BHF policy requires that to obtain a practice number, an applicant health care professional must be registered by a regulatory body or a licensing authority in terms of South African Law, as this is a requirement of the Medical Schemes Act (Act. No 131 of 1998).

Required Documents for Details Update

In accordance with Legislation and BHF Policies, a Practice Number may not be updated without the following supporting documents (tick what is relevant to you and has been submitted)

Board resolution for nominated and appointed proxy/signatory for the registration of the PCNS practice number (mandatory for facilities with more than 1 Director listed on the Company Registration documents)	<input type="checkbox"/>
Certified copy of the owner/appointed proxy's identifying document (mandatory): <ul style="list-style-type: none"> Identity Document or Passport and proof of permanent residence, <i>where the applicant is not a South African citizen.</i> 	<input type="checkbox"/>
Certified copy of a document issued by the Department of Home Affairs where the owner/appointed proxy's surname or name(s) differ on 2 or more supporting documents <ul style="list-style-type: none"> Marriage Certificate or Divorce Decree or A confirmation letter 	<input type="checkbox"/>
Document confirming the necessary permission to practice outside of the conditions of employment with your employer (Confirmation of Community of Service Completion/ Resignation letter/ RWOPS Application form/RWOPS Approval Certificate/Sessional work contract) (where applicable).	<input type="checkbox"/>
A stamped bank letter not older than 3 months accompanied by the attached bank verification form below, signed by the practice owner(s) or appointed proxy and the authorised bank account holder/signatory (mandatory)	<input type="checkbox"/>



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Banking Details Verification Form


To: BHF Client Services


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


Please ensure that the form is completed with the correct information. Please indicate whether the banking details are registered under an ID Number or a Company Registration number. Where the banking details are registered under the ID/Company Registration number of a 3rd party please submit a certified copy of the account owner's ID or a Copy of the Company Registration documents. The document needs to be signed by both the account holder and the practice owner where the banking details are registered under a 3rd party.

Please indicate if the banking details update also applies to your existing debit order transaction for your annual renewal fee <input type="checkbox"/>			
We recommend that you complete the form in BLOCK letters only OR/ type to complete. Unclear handwriting may delay the processing of your update for a PCN and lead to errors in the information captured			
Practice Number			
Bank Name			
Branch Name			
Account Holder Name (not account type)			
Account Number			
Account Type	Current	Savings	Transmission
Account Registration Type	ID Number(s)	Company Registration	Enter ID/Company Registration Number(s)
Authorised Bank Account Holder Initials and Surname/s		Authorised Bank Account Holders Signature/s	
NB: Digital signatures are not acceptable and may delay the processing of your update.			
SIGNATURE OF PRACTICE OWNER/APPOINTED PROXY		DATE	
FULL NAME AND SURNAME OF PRACTICE OWNER/APPOINTED PROXY			

NB: Should we wish to add a debit order for the deduction of your annual fees, please complete the below debit order instruction form.

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Bank Debit Order Instruction

We recommend that you complete the form in BLOCK letters only OR/ type to complete. Unclear handwriting may delay the processing of your update for a PCN and lead to errors in the information captured

Please be advised that there is an annual practice code number renewal fee payable before the 31st of March each year. Should you wish to activate a debit order instruction for the practice number renewal fee, please complete and authorise the below section. **Incomplete debit order information will not be accepted.**

Bank details for debit order transaction purposes only

The details of my/our account are as follows:

Practice Name:	
Practice Number:	
Bank Name:	
Account Holder Name:	
Account Number:	
Account Type:	

I/We hereby request and authorise BHF to debit my/our account with the annual PCNS renewal fee on either of the following dates (please select the applicable date):

☐ **February 28th**

☐ **March 31st**

This instruction may be cancelled by means of giving BHF 30 days' notice in writing. I/We understand that I/we shall not be entitled to refunds of amounts legally owing to BHF, which BHF has withdrawn whilst this instruction was in force.

I/We acknowledge that BHF 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 instruction to any third party before the written consent of the authorised party.

Signed at: _____ on this _____ day of _____ 20_____.

NB: Digital signatures are not acceptable and may delay the processing of your update.

_____ Authorised Bank Account Holder initials and Surname/s	_____ Authorised Bank Account Holders Signature/s
----------------------------------------------------------------	------------------------------------------------------

SIGNATURE OF PRACTICE OWNER/APPOINTED PROXY



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