

BOARD OF HEALTHCARE FUNDERS NPC Company Registration No. 2001/003387/08

Partnership Banking Details Verification Form

Please Note

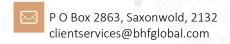
Please show by ticking the below that you have read and understood the information:

1	The completed update form can be sent to pcns_admin@bhfglobal.com	
2	As part of the application process, PCNS is required to verify the state employment of each applicant through the DPSA search: https://www.dpsa.gov.za/resource_centre/psverification/ . To ensure that your update form is processed timeously please ensure that the necessary approvals in the form of the below-listed documents have been submitted together with your update form: • 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. 	Ā
	Please also supply the contact details of the persons responsible to confirm the approval/resignation.	
	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 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 application 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.	
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.	
4	The Compliance and Risk Unit has been established to monitor adherence to the PCN System's Terms and Conditions.	
5	Should you have any Queries regarding this Application, please contact Client Services at +27 87 210 0500 or e-mail clientservices@bhfglobal.com	

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







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

SUPPORTING DOCUMENT CERTIFICATION

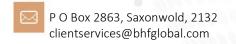
Applications <u>WILL NOT BE PROCESSED WITHOUT CERTIFIED COPIES OF ORIGINAL DOCUMENTATION</u> by a South African registered Commissioner of Oaths authority. The commissioner of oaths should be impartial, unbiased, not related to the Healthcare Service Provider (HSP), and who has no interest in the HSP (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, <u>and valid for 6 months from the date of certification</u>. 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)

Update form completed and signed by at least 2 partners (mandatory)	
Certified copy of the identifying documents of at least 2 partners linked to the partnership (mandatory): • Identity Document or • Passport and proof of permanent residence, where the applicant is not a South African citizen.	
Certified copy of a document issued by the Department of Home Affairs where the partner's surname or name(s) differ on 2 or more supporting documents • Marriage Certificate or • Divorce Decree or • A confirmation letter	
Document confirming the necessary permission to practice outside of the conditions of employment with the state for each partner employed by the state (Confirmation of Community of Service Completion/ Resignation letter/ RWOPS Application form/RWOPS Approval Certificate/Sessional work contract) (where applicable).	









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Partnership 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 may be updated on my new practice number application 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.

We recommend that you to errors in the informati		form in B	LOCK letters or	ly OR/ typ	e to complet	e. Unclear han	dwriting may dela	ay the processing	of your appl	ication for a l	PCN and lead
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Practice Number											
Practice Name											
Bank Name											
Branch Name											
Account Holder Name (not account type)											
Account Number										•	
Account Type	Current	Saving	s Transmis	sion							
Account Registration Type	ID Number	r(s)	Company Registration	Enter 1	D/Company l	Registration N	umber(s)				
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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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Partnership 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

Practice Name:				
Practice Number:				
Bank Name:				
Account Holder Name:				
Account Number:				
Account Type:				
his instruction may be cancelled by merfunds of amounts legally owing to BHF We acknowledge that BHF hereby authorised y of my/our obligations in terms of this instruged at:	to effect the drawing against my uction to any third party before t	vhilst this instruction value of the written consent of the day of	understand that I/we shall not be envas in force. e or assign its rights and that I/we may not authorised party.	ntitled t
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