PRACTICE CODE NUMBERING SYSTEM

A Division of the Board of Healthcare Funders

01 February 2025

BANK DETAILS UPDATE

Please Note

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

The completed update form can be sent to pcns_admin@bhfglobal.com	☐
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. • 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. 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 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	☐
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.	☐
The Compliance and Risk Unit has been established to monitor adherence to the PCN System's Terms and Conditions.	☐
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.

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REQUIRED DOCUMENTS FOR DETAILS UPDATE

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).

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 containing the details (*full name, surname, and identity number*) for the nominated and appointed proxy or signatory for registering the PCNS practice number, signed by at least two directors and the nominated proxy (***mandatory for facilities with more than one director listed on the company registration documents***).	☐
Certified copy of the owner/appointed proxy's identifying document (***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 owner/appointed proxy's surname or name(s) differ on 1 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 your employer *(Confirmation of Community of Service Completion/ Resignation letter/ RWOPS Application form/RWOPS Approval Certificate/Sessional work contract)* (***where applicable***).	☐
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***)	☐
Additional document(s) required for banking details owned by a 3rd party • A certified Identity Document copy for the Owner of the Bank account (***where the account holder is an individual***) or • Company registration documents and a certified copy of one director's Identity Document (***where the account holder is a registered company***)	☐

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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 or a Company Registration number.

A certified copy of the Identity Document for the owner of the bank account (where the account holder is an individual) or company registration documents and a certified copy of one director's Identity Document (where the account holder is a registered company) is required.

Please indicate if the banking details update also applies to your existing debit order transaction for your annual renewal fee ☐

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