PRACTICE CODE NUMBERING SYSTEM

A Division of the Board of Healthcare Funders

01 July 2026

PCNS UPDATE FORM

Please Note

Please show by ticking 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 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 in a timely manner, 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 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 for confirming 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.	☐
All Healthcare Service Providers in Public Service are required to submit the necessary renewals of approvals stipulated above annually to avoid suspension of their practice numbers.	☐
Update requests that fail PCNS verifications will not be processed. This is to ensure secure and accurate handling of your update.	
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 A DELAY IN THE PROCESSING OF UPDATING YOUR ACCOUNT.

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REQUIRED DOCUMENTS FOR DETAILS UPDATE

Please show by ticking 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. **The commissioner of oaths should be impartial, unbiased, not related to the Healthcare Service Provider (HSP), and have 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, include the name of the Commissioner of Oaths and the words COMMISSIONER OF OATHS, and be 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. The company registration details on the Board Resolution **[Name and Company Registration Number]** should match the Owner/Managing Body's CIPC documents. (***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 **[NB: Both sides (front and back) of the Smart Card ID must be submitted]** or • Passport and proof of permanent residence, ***where the applicant is not a South African citizen***. **Ensure that both the copy and the certification stamp are clear, legible, and valid.**	☐
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 **Ensure that both the copy and the certification stamp are clear, legible, and valid.**	☐
Document confirming the necessary permission to practice outside of the conditions of employment with your state employer *(Confirmation of Community of Service Completion/ Resignation letter/ RWOPS Application form/RWOPS Approval Certificate/Sessional work contract)* (***where applicable***).	☐
Proof of address for the practice's physical location ***(mandatory for address update requests)***	☐
Update form completed and signed by the owner or appointed proxy (***mandatory***)	☐

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WE RECOMMEND THAT YOU COMPLETE THE FORM IN BLOCK LETTERS ONLY, OR/ TYPE TO COMPLETE. UNCLEAR HANDWRITING MAY DELAY THE PROCESSING OF YOUR UPDATE AND LEAD TO ERRORS IN THE INFORMATION CAPTURED.

Practice Number _____ Practice Name _____

VAT Number (if applicable) _____ Tax Number (If applicable) _____

Government Employee | Yes | No | If yes, please provide the Certificate: Approval of other Remunerative Work

CONTACT DETAILS FOR THE PERSON RESPONSIBLE FOR CONFIRMING YOUR RWOPS/ NATURE OF STATE EMPLOYMENT

Name and Surname _____ Designation _____

Telephone Number _____ E-mail address _____

Practice Postal Address _____

_____

_____

Suburb _____

Town _____

Code _____

Province _____

Practice Physical Address _____

_____

_____

Suburb _____

Town _____

Code _____

Province _____

PRACTICE CONTACT DETAILS

PCNS can only register 1 set of contact details for the Landline, Cell phone, and Email Address fields

Landline Telephone Number (_____) _____ Cell Phone Number (_____) _____

(If no telephone number is provided, your cell phone number will be captured as the main telephone number on the system as this is a mandatory field.)

E-mail address _____

PLEASE ENSURE THAT YOU PROVIDE THE FULL CONTACT INFORMATION FOR BOTH THE APPLICANT AS WELL AS INFORMATION FOR YOUR NOMINATED EDI AND/OR BUREAU (MANDATORY IF AN EDI OR BUREAU COMPANY HAS BEEN SELECTED).

EDI User	EDI Company: _____	EDI website address: _____
Bureau	Telephone Number: _____ Email Address: _____	Bureau Name: _____ Bureau website address: _____

I, the undersigned, hereby declare that this above information is valid, correct, and reflects my personal information as of the date of signature hereof.

_____ _____

SIGNATURE OF PRACTICE OWNER/APPOINTED PROXY **DATE**

_____

FULL NAME AND SURNAME OF PRACTICE OWNER/APPOINTED PROXY

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