PRACTICE CODE NUMBERING SYSTEM

A Division of the Board of Healthcare Funders

01 July 2026

PARTNERSHIP BANK DETAILS UPDATE

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 documents listed below 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 that 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 the 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.

PRACTICE CODE NUMBERING SYSTEM

A Division of the Board of Healthcare Funders

01 July 2026

REQUIRED DOCUMENTS FOR 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 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, 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)

Banking details verification 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 **[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 partner'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.**	☐
A stamped bank account confirmation letter not older than 3 months, **that includes the Company Registration/ID/Passport number(s) used to register the banking details**. 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 • Company registration documents and a certified copy of one director's Identity Document ***(where the account holder is a registered company)*** - The CIPC documents should include: the page containing the enterprise information, and the page containing the Active members/Directors. **[NB: Both sides (front and back) of the Smart Card ID must be submitted]**	☐
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***).	☐

PRACTICE CODE NUMBERING SYSTEM

A Division of the Board of Healthcare Funders

01 July 2026

PARTNERSHIP BANKING DETAILS VERIFICATION FORM

To: BHF Client Services

I/ We declare that the details on this Banking Verification Form and the 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 or a Company Registration number.

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 APPLICATION FOR A PCN AND LEAD TO ERRORS IN THE INFORMATION CAPTURED.

Practice Number	
Practice Name	
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 Account Holder Initials and Surname/s**	_____ **Authorised Account Holders Signature/s**

The signatures of two or more partners linked to this application are required below, unless the application is for Solus Inc., then only one signature is required.

Full name and surname of partner: _____	**Signature:** _____	**Date:** _____
Full name and surname of partner: _____	**Signature:** _____	**Date:** _____
Full name and surname of partner: _____	**Signature:** _____	**Date:** _____

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

Please note that banking details are processed after the required internal verification and approval checks have been completed. As a result, the sharing of this information with the Medical Schemes may be delayed. This process is essential to ensure accuracy and to prevent unauthorised or fraudulent changes.

Please note that the completion and submission of the debit order instruction form attached hereto is mandatory.

T 087 210 0500 | Lower Ground Floor, South Tower, 1Sixty Jan Smuts, Rosebank, 2196 | P O Box 2863, Saxonwold, 2131

Company Registration No. 2001/003387/08

PRACTICE CODE NUMBERING SYSTEM

A Division of the Board of Healthcare Funders

01 July 2026

PARTNERSHIP BANK DEBIT ORDER INSTRUCTION

THE COMPLETION AND SUBMISSION OF THE DEBIT ORDER INSTRUCTION FORM IS MANDATORY

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

Please be advised that there is an annual practice code number renewal fee payable before the 31st of March each year. It is mandatory to activate a debit order instruction for the practice number renewal fee. Please complete and authorise the section below. **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):

☐ **End of April** ☐ **End of May** ☐ **End of June**

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 is 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**

The signatures of two or more partners linked to this application are required below; unless the application is for Solus Inc., then only one signature is required.

Full name and surname of partner: _____	**Signature:** _____	**Date:** _____
Full name and surname of partner: _____	**Signature:** _____	**Date:** _____
Full name and surname of partner: _____	**Signature:** _____	**Date:** _____