PRACTICE CODE NUMBERING SYSTEM

A Division of the Board of Healthcare Funders

01 July 2025

PARTNERSHIP UPDATE FORM

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 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 timely manner, please ensure that the necessary approvals for any of the partners in Public Service 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. 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 COMPLETED IN ADDITION TO THE SUPPORTING DOCUMENTATION REQUIRED TO BE SUBMITTED. FAILURE TO DO SO WILL RESULT IN THE DELAY OF PROCESSING UPDATING YOUR ACCOUNT.

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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)

Written consent signed by the previous practitioner(s) or estate/next of kin to retain the use of an existing practice name (***where the naming practitioner(s) of a partnership are no longer in private practice or are deceased***)	☐
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*****.**	☐
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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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

PARTNERSHIP, ASSOCIATION, OR INCORPORATED PRACTICE DETAILS

Practice Number: _____ Practice Name: _____

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

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: _____

We, the undersigned, hereby declare that this above information is valid, correct, and reflects the partnership information as of the date of signatures hereof.

The signature for 2 or more partners *(at least 1 signature being of one of the naming partner(s))* linked to this application is required unless the application is for a Solus INC then only 1 signature is required.

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.

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RWOPS CONTACT DETAILS

Please provide the contact details for the person responsible for confirming your RWOPS / nature of state employment for each partner employed by the state.

NB: Please be advised that due to the external validation process with your employer, the issuing of your practice number will be delayed.

Practitioner Name: ____________________ DESIGNATED AUTHORITY DETAILS Full Names: ____________________ Designation: ____________________ Email address: ____________________ Telephone Number: ____________________	Practitioner Name: ____________________ DESIGNATED AUTHORITY DETAILS Full Names: ____________________ Designation: ____________________ Email address: ____________________ Telephone Number: ____________________
Practitioner Name: ____________________ DESIGNATED AUTHORITY DETAILS Full Names: ____________________ Designation: ____________________ Email address: ____________________ Telephone Number: ____________________	Practitioner Name: ____________________ DESIGNATED AUTHORITY DETAILS Full Names: ____________________ Designation: ____________________ Email address: ____________________ Telephone Number: ____________________
Practitioner Name: ____________________ DESIGNATED AUTHORITY DETAILS Full Names: ____________________ Designation: ____________________ Email address: ____________________ Telephone Number: ____________________	Practitioner Name: ____________________ DESIGNATED AUTHORITY DETAILS Full Names: ____________________ Designation: ____________________ Email address: ____________________ Telephone Number: ____________________