01 November 2024

PARTNERSHIP UPDATE 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 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 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 COMPLETED IN ADDITION TO THE SUPPORTING DOCUMENTATION REQUIRED TO BE SUBMITTED. FAILURE TO DO SO WILL RESULT IN THE DELAY PROCESSING OF UPDATING YOUR ACCOUNT.

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 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)

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).	☐

PRACTICE CODE NUMBERING SYSTEM

A Division of the Board of Healthcare Funders

01 November 2024

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	Practice Physical Address
Practice Postal Address ____________________	Practice Physical Address ____________________
____________________	____________________
____________________	____________________
Suburb ____________________	Suburb ____________________
Town ____________________	Town ____________________
Code ____________________	Code ____________________
Province ____________________	Province ____________________

PRACTICE CONTACT DETAILS

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 linked to this practice 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.

PRACTICE CODE NUMBERING SYSTEM

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RWOPS CONTACT DETAILS

Please provide the contact details for the person responsible to confirm 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: ___