PRACTICE CODE NUMBERING SYSTEM

A Division of the Board of Healthcare Funders

01 July 2026

PARTNERSHIP DECLARATION AND AGREEMENT FORM

I/We, the undersigned, hereby declare that the information contained on the annexed application/update/reinstatement form is valid, and correct and reflects my/our personal information as of the date of signature hereof.

I/We duly authorise the Board of Healthcare Funders (BHF) to disseminate the information set out in the annexed application/update/reinstatement form with the BHF's member schemes/Administration Houses and/or PCNS Users for reimbursement purposes. To the extent that the information provided is not true and correct, I/we hereby indemnify the BHF against any claims which may be instituted against the BHF as a result of the incorrect information which I/we have provided to the BHF.

I/we undertake to promptly advise the BHF of any changes to my/our practice profile as and when such changes may occur.

I/We further declare that I will abide by the following:

I/We agree to annually renew my/our practice number and to pay the annual fee, as determined by BHF, towards the maintenance and running of the PCNS for the period that my/our practice number remains active by means of a debit order.

I/We acknowledge that failure to renew the registration on an annual basis and to pay the annual fee in respect of the maintenance and running of the PCNS will result in my/our practice number being rendered inactive.

I/We agree to comply with all relevant legislation, in particular the provisions of the Medical Schemes Act, 1998. In this regard, I/we agree to comply with the requirement to include diagnostic codes and the full cost on my/our accounts or statements used to claim benefits from medical schemes and administrators.

I/We declare that I/we will comply with the requirement of regulation 5(f) of the General Regulations of the Medical Schemes Act and will use the ICD 10 Code for this purpose.

I/We declare that I/we will comply with the requirement of regulation 5(h) of the General Regulations to the Medical Schemes Act, requiring the full cost of rendering service to be included on all accounts or statements.

I/we declare that I/we am/are registered with the relevant South African statutory body.

I/We agree to comply with all obligations in terms of the Income Tax Act.

I/We acknowledge that a practice number does not guarantee payment by a medical scheme or medical scheme administrator and shall under no circumstances attempt to recover any payment costs from the BHF, or unnecessarily involve the BHF in any disputes that I/we may have with a medical scheme administrator.

I/We agree that, in the event that I/we become aware of any fraudulent activities associated with my/or practice number, I/we will immediately notify the BHF thereof, and shall assist the BHF with any investigation action which may be taken by the BHF's Forensic Management Unit.

I/We agree to be bound by the BHF's policies and terms and conditions relating to the use of practice numbers as amended from time to time and shall familiarise myself/ourselves with the content of any updates to such policies and terms and conditions which the BHF may make from time to time and shall use the practice number only in accordance with the BHF's latest amendments and requirements pertaining to the use of the practice number.

01 July 2026

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.

PARTNERS, ASSOCIATES, SHAREHOLDERS, OR DIRECTORS' DETAILS

Please list all the partners, associates, shareholders, or directors who will be actively rendering service at this practice. Also note that it is essential that each partner, associate, shareholder, or director individually signs this form to give consent that their individual practice number is linked that they are fully in agreement with the application for a group practice number, and declare and accept that they have read and understood the Terms and Conditions listed.

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

Individual Practice Number _____

Name & Surname _____

ID Number _____

Signature to be linked _____

Individual Practice Number _____

Name & Surname _____

ID Number _____

Signature to be linked _____

Individual Practice Number _____

Name & Surname _____

ID Number _____

Signature to be linked _____

Individual Practice Number _____

Name & Surname _____

ID Number _____

Signature to be linked _____

Individual Practice Number _____

Name & Surname _____

ID Number _____

Signature to be linked _____

Individual Practice Number _____

Name & Surname _____

ID Number _____

Signature to be linked_____