PRACTICE CODE NUMBERING SYSTEM

A Division of the Board of Healthcare Funders

01 July 2026

PRACTICE NUMBER SUSPENSION REQUEST

The completed update form can be sent to pcns_admin@bhfglobal.com

Date: _____

Practice Number: _____

Council Number: _____

ID Number: _____

I, (full name and surname)_____

would like to request that PCNS suspend my/our Practice Code Number effective from (date) _____

Please note that the suspension effective date cannot exceed 30 (thirty) days from the date of submission. Furthermore, suspensions cannot be backdated.

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

_____ _____

SIGNATURE OF APPLICANT/NOMINATED PROXY **DATE**

_____

FULL NAME AND SURNAME OF APPLICANT/NOMINATED PROXY