

Health professionals billing practice details

Please send the completed form to Provider Administration, Discovery Health on 011 539 1039 or Provider_Administration@discovery.co.za
 Please remember to include copies of your identity document and your BHF/PCNS registration form.

1. Billing practice details (to be completed for the billing practice as a whole)

Billing practice name	<input type="text"/>		
Billing practice discipline	<input type="text"/>		
BHF billing practice number	<input type="text"/>	Group practice	Yes <input type="checkbox"/> No <input type="checkbox"/>
Practice numbers associated with group practice	<input type="text"/>	<input type="text"/>	<input type="text"/>

2. Billing practice contact details (to be completed for all satellite practices)

Physical address details	Practice 1	Practice 2
Building name and number	<input type="text"/>	<input type="text"/>
Street number	<input type="text"/>	<input type="text"/>
Street name	<input type="text"/>	<input type="text"/>
Suburb	<input type="text"/>	<input type="text"/>
City	<input type="text"/>	<input type="text"/>
Province	<input type="text"/>	<input type="text"/>
Postal code	<input type="text"/>	<input type="text"/>
Postal address details	Practice 1	Practice 2
PO Box number	<input type="text"/>	<input type="text"/>
Suburb	<input type="text"/>	<input type="text"/>
City	<input type="text"/>	<input type="text"/>
Province	<input type="text"/>	<input type="text"/>
Postal code	<input type="text"/>	<input type="text"/>
Contact details	Practice 1	Practice 2
(To be completed for the facility)		
Telephone number	<input type="text"/>	<input type="text"/>
Emergency number	<input type="text"/>	<input type="text"/>
Fax number	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>	<input type="text"/>

3. Personal credentials (to be completed by each health professional in the practice)

Full name of health professional

Dispensing license (if applicable)

ID number

Discipline type

Personal BHF practice number

HPCSA/Council number

Name of association

Are you a member of an IPA? Yes No

If **yes**, please specify

4. Personal practice address details (complete if different to the billing practice)

Physical address details (Complete if different to the billing practice)

Building name and number

Street number

Street name

Suburb

City

Province

Postal code

Postal address details (for clinical and personal communication)

PO Box number

Suburb

City

Province

Postal code

Contact details (for clinical and personal communication)

Telephone number Emergency Number

Fax number

Email address

Please attach copies of:

- ID document
- BHF/PCNS Registration Form

Health professional practice management and web access details

Please remember to include copies of your identity document and the practice's BHF/PCNS registration form.

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1. Practice manager details

Practice management details (to be completed for all satellite practices)

Practice number	<input type="text"/>	
	Practice Contact 1	Practice Contact 2
Practice manager name (title)	<input type="text"/> Name <input type="text"/>	<input type="text"/> Name <input type="text"/>
Surname	<input type="text"/>	<input type="text"/>
Practice manager ID number	<input type="text"/>	<input type="text"/>
Cell number	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Email address	<input type="text"/>	<input type="text"/>
Receptionist name (title)	<input type="text"/> Name <input type="text"/>	<input type="text"/> Name <input type="text"/>
	<input type="text"/>	<input type="text"/>
Receptionist ID number	<input type="text"/>	<input type="text"/>
Cell number	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Email address	<input type="text"/>	<input type="text"/>

2. Bureau services

Do you make use of a bureau service Yes No

Bureau name

Bureau contact name

Bureau telephone number

Bureau email address

3. Web access

Who must have access to the web
 Practice manager Bureau Receptionist

Full name of health professional

Health professional's signature Date

Contact person if there are problems loading the chosen individuals on the web:

Name Surname

Contact number Cell number

Email address

Please note that this process has a turnaround time of 48 hours. Please include copies of the individual's identity document.