

Permission to grant bureau access to practice information 2026



Contact us

Tel (members): **0860 99 88 77**, Tel (health partners): **0860 44 55 66**, PO Box 784262, Sandton, 2146, www.discovery.co.za.

Purpose of the form

To link personnel within your practice to the practice organisation and allow them to:

- Access information related to your practice on the Healthcare Professional Zone and HealthID.
- Make telephonic and email inquiries on your behalf.

What must the bureau do

- The bureau owner or manager must complete and sign section 1 and 2 of the form.
- Complete all fields in full and ensure that information (name, surname and ID number) completed in section 2 correlate with the ID documents of the bureau staff member.
- Completed form (section 1 and 2) must be sent to the healthcare professional to complete and sign section 3 of the form.
- Once the completed form is received from the healthcare professional the bureau must email the completed form to practice_updates@discovery.co.za.

What must the practice owner do

- The billing practice or head of the practice must complete all fields in section 3 of the form and sign this section, only once the bureau has fully completed all other sections.
- The completed and signed form must be sent back to the bureau to continue the process.

1. Bureau details

Name of bureau	
Branch name	
Telephone number of bureau	
Bureau email address	
Bureau manager	
Bureau manager ID number	
Bureau manager contact number	
Bureau manager's email address	
Number of staff employed at the bureau	
Number of providers you service	
Signature of bureau manager	
Date	

Please note: Your signature confirms that the details of the Bureau personnel provided are correct and these individuals are currently employed by the Bureau.

2. Bureau Practice personnel details

Please note: Practice personnel who are granted access to the HP Zone and HealthID will be able to view claims statements, benefit confirmation tools, patient clinical information, claims information, practice communication and tariff structures.

Send any future personnel changes or updates to contact details to provider_administration@discovery.co.za

[illegible]

3. Healthcare professional details (healthcare professional to complete)

Name(s)													
Surname													
Practice number										Speciality			
Physical address													
Unit/Suite number						Complex name							
Street number						Street name							
City									Postal code				
Postal address													
☐ PO Box	☐ Private Bag	Box number											
☐ Suite	☐ Postnet suite	Number											
Suburb													
City									Postal code				
Telephone													
Email													

The outcome of this application will be communicated to you by email.

Signature of healthcare professional

Date

D	D	M	M	Y	Y	Y	Y
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Send any future personnel changes or updates to contact details to provider_administration@discovery.co.za

[illegible]

Healthcare professional signature

Date

D

D

M

M

Y

Y

Y

Y

Disclaimer: This document, once signed by the doctor, grants the bureau the authority to add and remove staff members associated with the practice in the future. Importantly, the doctor’s signature will not be necessary for these administrative actions.

1. Protection of personal information disclaimer

By completing this form and providing healthcare services to members of the Schemes administered by Discovery Health, you agree to comply with the Protection of Personal Information Act No. 4 of 2013 (POPIA) and ensure that all personal data is handled in accordance with its provisions. Additionally, you acknowledge and agree to be bound by the terms and conditions of our Privacy Statement. You understand and accept that you will have access to the personal data of the members, which must be collected, used, and disclosed in accordance with the Discovery Health Privacy Statement, available [here](#).