# Discovery Health practice registration form 2022

**Contact us**

Tel (Members): 0860 99 88 77, Tel (Health partner): 0860 44 55 66, PO Box 784262, Sandton, 2146, www.discovery.co.za

**Purpose of the form**

To register an individual or group practice and all healthcare professionals linked to the group practice with Discovery Health.

**What you must do**

Please complete this form in full and email the completed form together with the relevant supporting documentation to practice_registration@discovery.co.za

**Supporting documentation to register an individual practice**

Please supply copies of the following documents:

- BHF client information sheet
- South African ID document or passport of the practitioner (Certified copies not older than 3 months)
- VAT registration document (if applicable)
- Dispensing license (if the practice dispenses medicine)
- A copy of the authorised signatories' ID document, passport or valid drivers license

**Supporting documentation required to register a group practice or incorporated practice**

Please supply copies of the following documents for all healthcare professionals linked to the group practice:

- BHF client information sheet of the group practice
- South African ID document or passport of all practitioners linked to the group practice (Certified copies not older than 3 months)
- VAT registration document (if applicable)
- Dispensing license (if the practice dispenses medicine)
- Letterhead signed by the signatory confirming all the healthcare professionals linked to the group practice
- Please provide a copy of ID document of signatory (Certified copies not older than 3 months)

**Please supply copies of the following additional documentation for the group practice:**

- Company registration document: Letterhead confirming the details of the owner of the practice together with a certified copy of their South African ID document
- Letterhead confirming the signatory of the practice and a certified copy of their South African ID document
- The Web Access form needs to be completed to link the signatory to the practice.
- Details of any special services rendered by the practice example rehabilitation, dialysis as well as copies of the relevant certification documents
- For **drug and rehabilitation centres**, please supply a certified copy of the registration documents from the Department of Social Development
- For ambulance services and psychiatric facilities, please supply a certified copy of a valid Department of Health certificate and a valid vehicle operating license.

*Note: We only provide registration for in-patient drug and rehabilitation facilities. Halfway houses will not be registered.*

## 1. Practice details

I wish to register the following practice: (Tick one)

☐ Individual practice ☐ Group practice

Name of practice

Practice number

Please supply the individual practice numbers associated with any group or partnership practice.

| BHF personal practice number/s | ID number | VAT registration number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Practice physical address**

Suite/Unit number | Complex name

Street number | Street name

Suburb | Post code

**Postal address (post collected from post box, suite or private bag)**

PO Box | Private Bag | Box number

Suite | Postnet Suite | Number

Suburb | Post code

**Contact details for the practice office**

Telephone | Cellphone

Email

Statement delivery email address

## 2. Contact details for the healthcare professional(s)

1. Name of healthcare professional:

Telephone (H) | Telephone (W)

Email | Cellphone

2. Name of healthcare professional:

Telephone (H) | Telephone (W)

Email | Cellphone -

3. Name of healthcare professional:

Telephone (H) | Telephone (W)

Email | Cellphone

4. Name of healthcare professional:

Telephone (H) | Telephone (W)

Email | Cellphone

5. Name of healthcare professional:

Telephone (H) | Telephone (W) -

Email | Cellphone

## 3. Practice signatory to complete the below

**Terms and conditions**

By completing this application form, you acknowledge and agree that:

- Your engagement with members and the Scheme is regulated by the Medical Schemes Act, applicable Scheme rules, all ethical guidelines (e.g. the HPCSA ethical booklet) and professional registration and conduct requirements including, if applicable, any Societal guidelines approved or adopted by the Scheme.
- You will provide services that are generally accepted to be clinically appropriate, medically necessary, cost-effective and carried out according to best practice.
- You will:
  - Submit claims only in respect of services actually rendered in accordance with procedures specified by the Scheme and if applicable, Discovery Health's payment arrangements and industry billing guidelines
  - Use appropriate codes and tariffs (including with any other practitioner or member) and not submit false, fraudulent or inflated claims
  - Create and keep records (both clinical and financial or billing related) in accordance with all statutory and regulatory requirements, and these records will be accurate, complete and legitimate
  - Provide all necessary and relevant information and records to the Scheme and/or Discovery Health as appointed administrator of the Schemes. This includes all patient and treatment records, stock purchase invoices, proof of equipment and consumables, appointment registers and any other information a medical scheme may view necessary to verify and confirm services for the purpose of paying claims.
- When providing any information or record as requested by the Scheme or Discovery Health:
  - You are aware that the Scheme and Discovery Health have the authority (as envisaged in the National Health Act, Protection of Personal Information Act and the Promotion to Access of Information Act and/or specific consent from members) to obtain the information and/or record from you/ your practice.
  - You may redact any information that may reasonably be deemed to not be relevant to validating a claim or the purpose for which the information is required.

The practice number allocated to you or your practice by the Board of Healthcare Funders (BHF) is a unique identifier that allows the medical scheme to determine who is providing services to its members. This practice number includes all the practice sites linked to your practice. You understand that you must submit claims for services at any of your practice sites only through the practice number allocated to your practice.

By completing this form, you acknowledge that the information supplied is true and correct.

**Your acceptance**

I, the undersigned, _____ agree to adhere to the terms of as set out in this agreement.

Signed at _____ on this _____ day of _____ 20 _ _

Signature _____