Discovery Health practice registration form 2024



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 with the relevant supporting documents to practice_registration@discovery.co.za.

Supporting documents to register an individual practice

Please supply copies of the following documents:

- · BHF client information sheet
- South African ID or passport of the practitioner (certified copies may not be older than 3 months)
- VAT registration document (if applicable)
- Dispensing licence (if the practice dispenses medicine)
- · A copy of the authorised signatory's ID document, passport or valid driving licence

Supporting documents needed to register a group practice or incorporated practice

Please give us 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 or passport of all practitioners linked to the group practice (certified copies may not be older than 3 months)
- VAT registration document (if applicable)
- Dispensing licence (if the practice dispenses medicine please add if applicable)
- Letterhead signed by the signatory confirming all the healthcare professionals linked to the group practice
- Please send us a copy of the ID of the signatory (certified copies may not be older than 3 months)

More supporting documents needed to register a group practice: *Only practices that are registered with Discovery Health can be linked to the group practice.

- Company registration document: Letterhead confirming the details of the owner of the practice and a certified copy of their South African ID.
- Letterhead confirming the signatory of the practice and a certified copy of their South African ID document.
- A completed Web Access form to link the signatory to the practice.
- Details of any special services the practice offers, such as rehabilitation and, dialysis as well as copies of the relevant certification documents.
- · For drug and rehabilitation centres, send us a certified copy of the registration documents from the Department of Social Development.
- For ambulance services and psychiatric facilities, send us a certified copy of a valid Department of Health certificate and a valid vehicle operating licence.

Note: We only register in-patient drug and rehabilitation facilities. We do not register halfway houses.

What you must do

Please complete all sections in full and email the completed form with the relevant supporting documents to practice_registration@discovery.co.za.

1. Practice details (compulsory)					
I want to register the follo	wing practice: (Tick one)			
Individual practice	Group practice	Incorporated practice			
Name of practice					
Practice number					

Practice physical address Suite/ant number	BHF personal prac		associated with group or partnership practice. ID number	VAT registration number
Sured number Street number Street number Suburb Postal address (post collected from post box, suite or private bag) PO Box Private Bag Box number Suburb PostNet Suite Number Suburb PostNet Suite Number Suburb PostNet Suite Number Suburb Postal code Contact details for the practice office Telephone Email 2. Contact details for the healthcare professional or practice owner (compulsory) 1. Name Sumame Maiden Sumame Telephone (W) Email 2. Name Sumame Maiden Sumame Telephone (W) Email 3. Name Sumame Maiden Sumame Maiden Sumame Telephone (W) Email 3. Name Sumame Maiden Sumame Maiden Sumame Telephone (W) Cellphone				3
Sured number Street number Street number Suburb Postal address (post collected from post box, suite or private bag) PO Box Private Bag Box number Suburb PostNet Suite Number Suburb PostNet Suite Number Suburb PostNet Suite Number Suburb PostNet Suite Number Suburb Postal code Contact details for the practice office Telephone Email 2. Contact details for the healthcare professional or practice owner (compulsory) 1. Name Sumame Maiden Sumame Telephone (W) Email 2. Name Sumame Maiden Sumame Telephone (W) Email 3. Name Sumame Maiden Sumame Telephone (W) Email 3. Name Sumame Maiden Sumame Telephone (W) Email Cellphone				
Sured number Street name Suburb Postal code Postal address (post collected from post box, suite or private bag) PO Box Private Bag Box number Suburb PostNet Suite Number Suburb PostNet Suite Number Suburb PostNet Suite Number Suburb PostNet Suite Number Suburb Postal code Contact details for the practice office Telephone Email 2. Contact details for the healthcare professional or practice owner (compulsory) 1. Name Sumame Maiden Sumame Telephone (W) Email 2. Name Sumame Maiden Sumame Telephone (W) Email 3. Name Sumame Maiden Sumame Telephone (W) Email Cellphone				
Sured number Street name Suburb Postal code Postal address (post collected from post box, suite or private bag) PO Box Private Bag Box number Suburb PostNet Suite Number Suburb PostNet Suite Number Suburb PostNet Suite Number Suburb PostNet Suite Number Suburb Postal code Contact details for the practice office Telephone Email 2. Contact details for the healthcare professional or practice owner (compulsory) 1. Name Sumame Maiden Sumame Telephone (W) Email 2. Name Sumame Maiden Sumame Telephone (W) Email 3. Name Sumame Maiden Sumame Telephone (W) Email Cellphone				
Sured number Street name Street number Street name Suburb Postal code Postal address (post collected from post box, suite or private bag) PO Box				
Sured number Street name Street number Street name Suburb Postal code Postal address (post collected from post box, suite or private bag) PO Box				
Sured number Street name Street number Street name Suburb Postal code Postal address (post collected from post box, suite or private bag) PO Box				
Sured number Street name Street number Street name Suburb Postal code Postal address (post collected from post box, suite or private bag) PO Box				
Sured number Street name Street number Street name Suburb Postal code Postal address (post collected from post box, suite or private bag) PO Box				
Sured number Street name Street number Street name Suburb Postal code Postal address (post collected from post box, suite or private bag) PO Box				
Sured number Street name Street number Street name Suburb Postal code Postal address (post collected from post box, suite or private bag) PO Box				
Street name Suburb Postal address (post collected from post box, suite or private bag) PO Box Postal address (post collected from post box, suite or private bag) PO Box PostNet Suite Suburb PostNet Suite Number Suburb Postal code Contact details for the practice office Telephone Email 2. Contact details for the healthcare professional or practice owner (compulsory) 1. Name Sumame Maiden Sumame Telephone (W) Cellphone		ddress		
Suburb Postal code Postal address (post collected from post box, suite or private bag) PO Box Private Bag Box number Suite PostNet Suite Number Suburb Contact details for the practice office Telephone Cellphone Email 2. Contact details for the healthcare professional or practice owner (compulsory) 1. Name Surname Maiden Surname Meiden Surname Celliphone Celliphone Celliphone Celliphone Celliphone Celliphone	Suite/unit number		Complex name	
Postal address (post collected from post box, suite or private bag) PO Box Private Bag Box number Sultite PostNet Suite Number Suburb Postal code Contact details for the practice office Telephone Cellphone Email 2. Contact details for the healthcare professional or practice owner (compulsory) 1. Name Surname Maiden Surname Celiphone Celiphone Celiphone Celiphone	Street number		Street name	
Pro Box Private Bag Box number Sultite PostNet Suite Number Suburb Postal code Contact details for the practice office Telephone Cellphone Email 2. Contact details for the healthcare professional or practice owner (compulsory) 1. Name Surname Maiden Surname Telephone (W) Cellphone Email 3. Name Surname Maiden Surname Maiden Surname Telephone (W) Cellphone Email 3. Name Maiden Surname Maiden Surname Maiden Surname Cellphone (W) Cellphone	Suburb			Postal code
Suite PostNet Suite Number Suburb Postal code Contact details for the practice office Email 2. Contact details for the healthcare professional or practice owner (compulsory) 1. Name Surname Maiden Surname Telephone (W) Cellphone Email 3. Name Surname Maiden Surname Maiden Surname Maiden Surname Telephone (W) Cellphone Email 3. Name Surname Maiden Surname	Postal address (pos	st collected from pos	box, suite or private bag)	
Suburb Contact details for the practice office Telephone Email 2. Contact details for the healthcare professional or practice owner (compulsory) 1. Name Surname Maiden Surname Telephone (W) Email 2. Name Surname Maiden Surname Maiden Surname Maiden Surname Maiden Surname Telephone (W) Email 3. Name Surname Maiden Surname Maiden Surname Maiden Surname Cellphone	PO Box	Private Bag	Box number	
Contact details for the practice office Telephone	Suite	PostNet Suite	Number	
Telephone Cellphone Cellph	Suburb			Postal code
Email 2. Contact details for the healthcare professional or practice owner (compulsory) 1. Name Surname Maiden Surname Telephone (W) Cellphone Surname Maiden Surname Telephone (W) Cellphone	Contact details for	the practice office		
2. Contact details for the healthcare professional or practice owner (compulsory) 1. Name Surname Maiden Surname Telephone (W) Cellphone Surname Maiden Surname Telephone (W) Cellphone Telephone (W) Cellphone Telephone (W) Cellphone	Telephone		Cellphon	e
1. Name Surname Maiden Surname Telephone (W) Email 2. Name Surname Maiden Surname Telephone (W) Cellphone Telephone (W) Cellphone Telephone (W) Cellphone Telephone (W) Cellphone Cellphone Cellphone	Email			
Surname Maiden Surname Telephone (W) Email 2. Name Surname Maiden Surname Telephone (W) Email 3. Name Surname Maiden Surname Cellphone Cellphone Cellphone Cellphone	2. Contact details	s for the healthcare	professional or practice owner (compulsory	')
Maiden Surname Telephone (W) Cellphone Email 2. Name Surname Maiden Surname Telephone (W) Cellphone Surname Cellphone Cellphone Cellphone Cellphone Cellphone Cellphone	1. Name			
Telephone (W) Email 2. Name Surname Maiden Surname Telephone (W) Cellphone Telephone (W) Cellphone Telephone (W) Cellphone Telephone (W) Cellphone Cellphone	Surname			
Telephone (W) Email 2. Name Surname Maiden Surname Telephone (W) Cellphone Telephone (W) Cellphone Telephone (W) Cellphone Telephone (W) Cellphone Cellphone	Maiden Surname			
Email 2. Name Surname Maiden Surname Telephone (W) Cellphone 3. Name Surname Maiden Surname Telephone (W) Cellphone Cellphone	Telephone (W)		Cellphon	e
2. Name Surname Maiden Surname Telephone (W) Email 3. Name Surname Maiden Surname Telephone (W) Cellphone Cellphone Cellphone				
Surname Maiden Surname Telephone (W) Email 3. Name Surname Maiden Surname Telephone (W) Cellphone Cellphone				
Maiden Surname Telephone (W) Email 3. Name Surname Maiden Surname Telephone (W) Cellphone Cellphone	2. Name			
Telephone (W) Email 3. Name Surname Maiden Surname Telephone (W) Cellphone Cellphone	Surname			
Email 3. Name Surname Maiden Surname Telephone (W) Cellphone	Maiden Surname			
3. Name Surname Maiden Surname Telephone (W) Cellphone	Telephone (W)		Cellphon	e
Surname Maiden Surname Telephone (W) Cellphone	Email			
Surname Maiden Surname Telephone (W) Cellphone				
Maiden Surname Telephone (W) Cellphone	3. Name			
Telephone (W)	Surname			
	Maiden Surname			
	Telephone (W)		Cellphon	e
	Email			

4. Name								
Surname								
Maiden Surname								
Telephone (W)				Cellphone				
Email								
5. Name								
Surname								
Maiden Surname								
Telephone (W)				Cellphone				
Email								

3. Terms and conditions

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

- Your engagement with members and the Scheme is regulated by:
 - · The Medical Schemes Act
 - Applicable Scheme rules
 - · All ethical guidelines (such as the HPCSA ethical booklet)
 - · Professional registration and conduct requirements including, if applicable, any societal guidelines the Scheme approved or adopted.
- You will provide services that are generally accepted to be clinically appropriate, medically necessary, and cost-effective. You also agree to carry the services out according to best practice.
- You will:
 - Submit claims only for services you actually rendered in according to 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) according to all statutory and regulatory requirements, and these records will be accurate, complete and legitimate.
 - Give the Scheme and Discovery Health (as the appointed administrator of the scheme) all necessary and relevant information and records. 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 to pay claims.
- When providing any information or record the Scheme or Discovery Health requires:
 - 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 get the information and record from you or 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 we need the information.

The practice number Board of Healthcare Funders (BHF) allocated to you or your practice 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.

rour acceptance	
I, the undersigned,	agree to adhere to the terms as set out in this agreement.
Signed at (town or city)	$egin{array}{ c c c c c c c c c c c c c c c c c c c$
Signature	