

Discovery
Health

Practice physical address

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

Contact details for the practice office

2. Contact details for the healthcare professional or practice owner (compulsory)

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

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

3. Healthcare professional banking details for the payment of claims

The account holder must sign the form.

Attach the following documents:

- Copy of the ID, passport or valid driving licence of the requestor and authorised signatories (not older than 3 months).
- Copy of a letter with an original stamp from the bank (on an official letterhead) showing the accountholder's name, account number, account type and branch code (not older than 3 months).

OR

- Copy of a bank statement with an original bank stamp that confirms the account holder's name, account number, account type and branch code (not older than 3 months)

Please note: This request to add your banking details applies to the payment of claims and enables us to accurately add banking details. It will take us up to three working days to add your banking details and we may contact you to validate this request. If you need us to pay into the new account, please do not submit claims until you have received a notification from us that we have added the banking details for consistency. Claims will be paid from the date we verify and add the banking details, and not from the service date

Please note that banking details cannot be added without the company's registration number or ID number.

4. Banking details

Is the account registered with a person's identity number (ID) or is it a company registration number?

ID number		Company registration number	
ID or passport number			
Company registration number			

Please note: We cannot accept credit card account details

Bank name																	
Branch name									Branch code			-			-		
Account number												Type of account	Cheque		Savings		
Account holder																	

The above details apply to: Premier Plus monthly fee Normal claims Both

Please make sure that you have captured the account details correctly. Your banking details will only be added if all the details you have supplied on this form corresponds with the information on our system and the request has been signed by the practice owner or authorised signatory in section 1.

Contact person																							
Telephone (H)												Telephone (W)											
Cellphone																							
Email																							
Signed at (town or city)													Date										

Signature of authorised account holder	
Signature of requestor	

Disclaimer:

We will pay all money that is due to the healthcare provider using the banking details for consistency and we cannot be held liable for any loss due to incorrect banking details supplied.

5. 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.

Your acceptance

I, the undersigned,		agree to adhere to the terms as set out in this agreement.								
Signed at (town or city)		on <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			
Signature										

6. 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](#).