

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.

1. Practice details (compulsory)

I want to register the following practice: (Tick one) Individual practice Group practice Incorporated practice

Name of practice

Practice number

Please fill in the individual practice numbers associated with group or partnership practice.

BHF personal practice numbers	ID number	VAT registration number
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

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,	<input type="text"/>	agree to adhere to the terms as set out in this agreement.								
Signed at (town or city)	<input type="text"/>	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	<input type="text"/>									

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](#).