


PCNS UPDATE FORM


Please Note


Please show by ticking the below that you have read and understood the information :

1	The completed update form can be sent to pcns_admin@bhfglobal.com	<input type="checkbox"/>
2	<p>As part of the application process, PCNS is required to verify the state employment of each applicant through the DPSA search: https://www.dpsa.gov.za/resource_centre/psverification/. To ensure that your update form is processed timeously please ensure that the necessary approvals in the form of the below-listed documents have been submitted together with your update form:</p> <ul style="list-style-type: none"> • Confirmation of Community of Service Completion • Resignation letter • RWOPS Approval Certificate • RWOPS Application form. NB: The RWOPS Application form should be stamped, dated, and signed by both the employer and designated authority and should have exceeded the 30-day submission period with your state employer • Sessional Work Contract. <p>Please also supply the contact details of the persons responsible to confirm the approval/resignation.</p> <p>Once your approval (Confirmation of the end of Community Service/Resignation letter/RWOPS Approval Certificate/RWOPS Application Form/Sessional Work Contract) has been received we are going to perform validation with your employer. We will contact the employer at the state facility via email and telephone to verify that approval has been granted for remunerative work outside the public service or if the nature of your employment allows for private practice. Thus, we urge you to provide the correct contact information for the employer on the application form to ensure the process is not delayed. We also encourage you to advise your employer that the validation will take place, so they are aware.</p>	<input type="checkbox"/>
3	All Healthcare Service Providers who are in Public Service are required to submit the renewed necessary approvals stipulated above annually to avoid the suspension of their practice numbers.	<input type="checkbox"/>
4	The Compliance and Risk Unit has been established to monitor adherence to the PCN System's Terms and Conditions.	<input type="checkbox"/>
5	Should you have any Queries regarding this Application, please contact Client Services at +27 87 210 0500 or e-mail clientservices@bhfglobal.com	<input type="checkbox"/>

KINDLY NOTE THIS UPDATE FORM MUST BE FULLY COMPLETED IN ADDITION TO THE SUPPORTING DOCUMENTATION REQUIRED TO BE SUBMITTED. FAILURE TO DO SO WILL RESULT IN THE DELAY IN THE PROCESSING OF UPDATING YOUR ACCOUNT.

 Lower Ground Floor, South Tower
1Sixty Jan Smuts, Rosebank, 2196

 P O Box 2863, Saxonwold, 2132
clientservices@bhfglobal.com

 T 087 210 0500

DIRECTORS NJ Khauoe (Chairperson) • G Goolab (Deputy Chairperson) • JK Mothudi (Managing Director) • GA Bartlett • LR Callakoppen • DC Carolus • BC Kamanga (Malawi) • NPB Khumalo • JH Joubert • SM Mkhonta (eSwatini) • TM Mloyi-Ncube (Zimbabwe) • CM Mokgosana (Botswana) • BOS Moloabi • FM Mosoeu • MS Mphomela • RR Nandkoomar • FV Nompumza • HC Schäfer (Namibia) • MC Wilson

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SUPPORTING DOCUMENT CERTIFICATION

Applications WILL NOT BE PROCESSED WITHOUT CERTIFIED COPIES OF ORIGINAL DOCUMENTATION by a South African registered Commissioner of Oaths authority. The commissioner of oaths should be impartial, unbiased, not related to the Healthcare Service Provider (HSP), and who has no interest in the HSP (such as any immediate family members of the HSP, any employee or employer of the HSP, or any colleague of the HSP). The stamp on the certified document must be dated, including the name of the Commissioner of Oaths and the words COMMISSIONER OF OATHS, and valid for 6 months from the date of certification. Please note that the BHF policy requires that to obtain a practice number, an applicant health care professional must be registered by a regulatory body or a licensing authority in terms of South African Law, as this is a requirement of the Medical Schemes Act (Act. No 131 of 1998).

Required Documents for Details Update

In accordance with Legislation and BHF Policies, a Practice Number may not be updated without the following supporting documents (tick what is relevant to you and has been submitted)

Board resolution for nominated and appointed proxy/signatory for the registration of the PCNS practice number (mandatory for facilities with more than 1 Director listed on the Company Registration documents)	<input type="checkbox"/>
Certified copy of the owner/appointed proxy's identifying document (mandatory): <ul style="list-style-type: none"> Identity Document or Passport and proof of permanent residence, <i>where the applicant is not a South African citizen</i>. 	<input type="checkbox"/>
Certified copy of a document issued by the Department of Home Affairs where the owner/appointed proxy's surname or name(s) differ on 2 or more supporting documents <ul style="list-style-type: none"> Marriage Certificate or Divorce Decree or A confirmation letter 	<input type="checkbox"/>
Document confirming the necessary permission to practice outside of the conditions of employment with your state employer (Confirmation of Community of Service Completion/ Resignation letter/ RWOPS Application form/RWOPS Approval Certificate/Sessional work contract) (where applicable).	<input type="checkbox"/>
Update form completed and signed by the owner or appointed proxy (mandatory)	<input type="checkbox"/>



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PCNS UPDATE FORM

We recommend that you complete the form in **BLOCK** letters only OR/ type to complete. Unclear handwriting may delay in the processing of your application for a PCN and lead to errors in the information captured

PRACTICE DETAILS

Practice number: _____ Practice Name: _____

Practice Postal Address _____

Practice Physical Address _____

Suburb _____

Suburb _____

Town _____

Town _____

Code _____ Province _____

Code _____ Province _____

Telephone Number (_____) _____

Cell Number (_____) _____

(If no telephone number is provided your cell phone number will be captured as the main telephone number on the system as this is a mandatory field)

E-mail Address _____

Government employee (Yes) or (No) If yes, please provide Certificate: Approval of other Remunerative Work

CONTACT DETAILS FOR PERSON RESPONSIBLE TO CONFIRM YOUR RWOPS APPROVAL/NATURE OF STATE EMPLOYMENT

Name and Surname _____ Designation _____

Telephone Number _____ E-mail address _____

NB: Please be advised that due to the external validation process with your employer, the updating of your practice information will be delayed.

I, the undersigned, hereby declare that this above information is valid, correct, and reflects my personal information as of the date of signature hereof.

SIGNATURE OF OWNER/APPOINTED PROXY

DATE

FULL NAME AND SURNAME OF OWNER/APPOINTED PROXY

NB: Digital signatures are not acceptable and may delay the processing of your update.



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