HEALTHCARE PROVIDER IMPLEMENTATION FORM

Implementation Type: New ☐ Change of Details ☐ IM Number:

BHF/ Practice No*: Practice/ Provider Name*:

AHPCSA/HPCSA/ SANC No: DOH Dispensing Licence No:

PRACTICE CONTACT DETAILS

Postal Address:

Code:

Physical Address

Building/Complex/ Centre Name:

Floor Number: Room/Shop/Suite Number:

Street Number & Name:

Suburb Name:

Town/City Name:

Code:

Province Name:

Telephone Number: Cell Number:

PRACTICE EMAIL ADDRESSES

Primary Email address*:

(This address will be used if no other email addresses are supplied)

Delayed Adjudication Scheme Specific responses*:

PRACTICE EMAIL ADDRESSES (continued)

Statements: Email 1:

Email 2:

Email 3:

VAT Invoices: Email 1:

Email 2:

Email 3:

Claim Summary Reports Acknowledgments Email 1:

Email 2:

Email 3:

VAT No. (If available):

PRACTICE LINKING DETAILS

*** MediKredit Effective Date: Effective date will be backdated by 120 days of receipt of request. Specify date ONLY if further backdating is required:**

DD/MM/YYYY

MediKredit Representative:

Vendor Software*:

Dealer Name:

Bureau Name:

Network/s:

Network Effective Date: Same as MK effective date

DD/MM/YYYY

Network Termination Date:

DD/MM/YYYY

Special Instructions:

Direct Contract:

MediKredit requires a letter from your bank (not older than 3 months) confirming that an account is open, for validation purposes, and page 4 of this form must be completed and returned to MediKredit. If the banking details as recorded on page 4 changes, please complete page 4 of the form which can be downloaded from www.medikredit.co.za. or contact the MediKredit Call Centre on 0860 932 273.

PRACTICE LINKING DETAILS (continued)

I hereby declare the above information to be true and correct.

Name: Capacity:

Signature*: Date:

DD/MM/YYYY

Who by his/her signature hereto warrants that he/she is duly authorised thereto.

The completed form must be uploaded on the website or emailed to **implementationsdept@medikredit.co.za**

Columns/fields marked with * are mandatory and forms will not be accepted if this information is not supplied/completed.

BANKING DETAILS CHANGE / DEBIT ORDER AUTHORISATION

Implementation Type: New ☐ Change of Details ☐ IM Number: _____

BHF/ Practice No*: _____ Practice/ Provider Name*: _____

BANKING DETAILS*

Name of Account Holder:	
Name of Bank:	
Branch:	
Account Number:	
Branch Code:	

Type of Account: Select one of the following

Current ☐ Transmission ☐ Savings ☐ Other _____

MEDIKREDIT PRACTICE/PROCESSING FEE AUTHORISATION

I hereby instruct and authorise MediKredit Integrated Healthcare Solutions (Pty) Ltd to draw against my bank account all amounts (current and arrears) which are due and payable by me in terms of the MediKredit Practice/Processing Fees (PAF), or any charges resulting from a rejection of the debit order from my/our account. It is recorded that in the event that a debit order rejects for any reason other than termination of MediKredit' s services, MediKredit shall then implement a manual collection process for fees that are due and payable. Should either party wish to withdraw from this agreement, then such party must give 30 days' notice in writing of such party's intention to cancel the MediKredit services.

Signature of Account Holder*: _____ Date: _____ DD/MM/YYYY

Who by his/her signature hereto warrants that he/she is duly authorised thereto.

Signature of Account Holder*: _____ Date: _____ DD/MM/YYYY

Who by his/her signature hereto warrants that he/she is duly authorised thereto.

NOTES

Please note: MediKredit requires a letter from your bank **(Not older than 3 months)** confirming that an account is open, for validation purposes. If the banking details as recorded above changes, please **complete this form which can be downloaded from www.medikredit.co.za or contact the MediKredit Call Centre on 0860 932 273**.

The completed form must be uploaded on the website or emailed to **implementationsdept@medikredit.co.za**

I hereby declare the above information to be true and correct. I authorise MediKredit to collect all amounts due and owing to MediKredit by means of the billing method as specified above.

Name: Capacity:

Signature*: Date:

DD/MM/YYYY

Who by his/her signature hereto warrants that he/she is duly authorised thereto.

Columns/fields marked with * are mandatory and forms will not be accepted if this information is not supplied/completed.