Membership Application 2018

This agreement serves to clarify the nature and extent of co-operation between ProfNet Medical (Pty) Ltd and

Name _____

Practice name_____

Discipline _____ (One form per discipline)

This member application form serves as a membership agreement only.

I, the undersigned Healthcare Professional, undertake to complete the required questionnaires, and to assist ProfNet Medical with healthcare support information and data monitoring procedures as established by ProfNet Medical.

I hereby give ProfNet authority to identify and gather all necessary information that has been generated by my practice from the following organisations to be made available to ProfNet in order to assist on a National Healthcare Data Portal - MediKredit (Pty) Ltd, Medscheme Holdings (Pty) Ltd, HealthBridge, MediSwitch, Mediscor, Private Hospital Networks or any other Healthcare Organisations in possession of my practice data. ProfNet undertakes not to disclose any part of my practice information to any individual / health care group / third party, without my written consent.

I hereby give ProfNet consent to advise, assist, support and communicate on any current or future third party arrangements that I may independently enter into, and where appropriate, to offer administrative support and to liaise on compliance policies on my behalf.

Where appropriate, and in agreement between ProfNet and myself, I hereby give consent to commercialize my product utilization data with the Healthcare Industry.

I confirm that in the past 5 years, no claims, HPCSA (or equivalent Regulatory or Statutory body) complaints or allegations of negligence, error or omission have been made against me, nor am I aware of any circumstances which may result in any such claim, allegation or complaint being made against me. No insurer has ever cancelled, declined or refused to renew my malpractice/professional indemnity insurance. The MPS has never declined to renew my membership with them.

Sign:_____

This document also authorizes ProfNet to communicate with me via electronic media (sms and e-mail) where appropriate. One calendar months' notice period on subscription changes and contract termination is required.

Signed at _____ on _____2018

_____	_____	_____
Member: Signature	Member: Tel. number	Email address

PRACTICE & PERSONAL INFORMATION

Practice name As you would like it to appear on official documents	
Practice number (BHF no.)	
Email address This will be your username when logging in, as well as where you will receive your confirmation email.	
Title	
Initials	
Name	
Surname	
Identity no / SA ID / Passport	
Gender	
Discipline	
Regulatory council number HPCSA, AHPCSA, SANC, SACSSP, SADTC etc.	
Physical address	Building / Unit:
	Complex / Estate:
	Street address:
	Suburb:
	City/Town: | Postal Code:
Postal address	
VAT number (if applicable)	

PRACTICE ADMINISTRATION

Receptionist name			
Administrator			
Admin Tel no			
Admin Fax no			
Admin email address			
Which practice billing software do you use?			
Do you submit your claims by EDI or paper?			
Which electronic switching software do you use?			
Does your practice have a credit card machine (POS)	If Yes:	Bank:	Merchant no:
	If No:	I would like a POS Facility:	☐ Yes ☐ No
		Preferred bank:	ABSA / Nedbank / Std Bank / FNB

Healthcare Helpline

Tel: 012 683 0379

Fax: 086 242 0567

Email: info@profnetmedical.co.za

PROFNET DEBIT ORDER AUTHORISATION FORM 2018

Initials & surname		
First name		
Practice name		
Practice number (BHF / PCNS no)		
Contact Person		
Telephone Number and E-mail address		

All pricing is VAT inclusive

ProfNet Membership (Monthly Fee)	**Plan 1** ☐ Free	**Plan 2** ☐ R226.97	**Plan 3** ☐ R458.99

EZMED OPTIONS (MONTHLY FEE)

EZMed Practice Management Application (PMA) *Includes 1 practice with 1 clinician.* *Additional clinicians @ R172.50 each per month*	**ProfNet Plan 1** ☐ R736.40	**On ProfNet Plan 2** ☐ R575.00	**On ProfNet Plan 3** ☐ R458.99
EZMed EDI EDI is an additional functionality to the EZMed system and includes 50 switches per month. *EDI Base cost – R 172.50 per month*	☐ R172.50/month – includes 50 switches R 4.54 per switch exceeding 50/month R 1.73 per EZCheck		

- The switching fee will be charged on all successful claims, including those successful claims that are reversed by the practice
- It is the practices responsibility to register their practice number against which they are claiming with the BHF, and ensure that all medical schemes have the practice details registered with them as required, to ensure that payment is made into the relevant practice bank account.
- Should the funder not accept EDI claims, it is the practices responsibility to print paper claims and submit those claims manually to those particular medical aids.

EDI EFFECTIVE DATE: _____

INITIAL:_____

PLEASE TURN OVER

V2018.2

MPI OPTIONS (MONTHLY FEE)

Malpractice Insurance A Only available for Plan 2 and Plan 3 members ***Only for:*** *Speech-Language Therapists, Audiology, Speech Correctionists, Hearing Aid Acousticians, Podiatrists*	**R2,5 million** ☐ R110.96	**R5 million** ☐ R136.18	**R10 million** ☐ R201.75
Malpractice Insurance B Only available for Plan 2 and Plan 3 members ***Only for****: Psychologists, Psychometrists,* ***Psycho****therapists, Hypnotherapists, Registered Counsellors, Social Workers, Art Therapists,* ***Phyto****therapists*	**R2,5 million** ☐ R191.67	**R5 million** ☐ R252.19	**R10 million** ☐ R312.72

Malpractice Insurance cover will be effective from the date your membership *is verified*. In order to have continuous Malpractice Cover, please ***ensure that there is no gap in cover*** when switching over from another MPI policy.

☐ I confirm that in the past 5 years, no claims, HPCSA (or equivalent Regulatory or Statutory body) complaints or allegations of negligence, error or omission have been made against me, nor am I aware of any circumstances which may result in any such claim, allegation or complaint being made against me.

☐ No insurer has ever cancelled, declined, or refused to renew my malpractice/professional indemnity insurance. The MPS has never declined to renew my membership with them.

COMMENTS:

MPI EFFECTIVE DATE: _____

DEBIT ORDER INSTRUCTION

BANKING DETAILS

Bank:		Account type:	
Account no:		VAT no:	
Debit Order Activation date:		***Total per month:**	

* *For Membership and License fees only. Monthly additional chargeable amounts are not included.*

Abbreviated name as registered with the bank: ProfNet

I/We hereby instruct and authorize ProfNet Medical (Pty) Limited to debit the abovementioned bank account, in relation to the amount of the Service Plan Option above, on the first (1st) day of every month, from the stipulated date, and continuing until terminated by me/us in writing. All such withdrawals from my bank account, by ProfNet Medical, shall be treated as though been signed by me/us personally.
I/We understand that the withdrawals hereby authorized will be processed through a computerized system provided by the South African Banks and I/We also understand that details of each withdrawal will be printed on my bank statement or on an accompanying voucher. I/We agree to pay bank charges relating to this debit order.
The authority may be cancelled by me/us, by giving one calendar months' notice in writing. Cancellation of this Debit Order instruction will not necessarily imply that the agreement between me/us and ProfNet Medical is also automatically cancelled. The agreement between me/us and ProfNet Medical is governed by a separate agreement, I/We further understand that I/We shall not be entitled to any refund of amounts which have been withdrawn, while this authority was in force, if such amounts were legally owing to you. Receipt of this instruction shall be regarded as receipt thereof by my/our bank.
I/We acknowledge that this Authority may be ceded or assigned to a third party if the Agreement between me/us and ProfNet Medical is also ceded or assigned to that third party, but in the absence of such assignment of the Agreement between me/us and ProfNet Medical, this Authority and Mandate cannot be assigned to any third party.

PLEASE FAX TO: 086 242 0567 OR EMAIL TO: INFO@PROFNETMEDICAL.CO.ZA IN ORDER TO GET ACCESS

Signed: _____ Date: _____