Permission to grant bureau access to practice information 2024

Discovery

Contact us

Tel (members): **0860 99 88 77**, Tel (health partners): **0860 44 55 66**, PO Box 784262, Sandton, 2146, **www.discovery.co.za**.

Purpose of the form

To link personnel within your practice to the practice organisation and allow them to:

- Access information related to your practice on the Healthcare Professional Zone
- Make telephonic and email inquiries on your behalf.

What must the bureau do

- The bureau owner or manager must complete and sign section 1 and 2 of the form.
- Complete all fields in full and ensure that information (Name, Surname and ID number) completed in section 2 correlate with the ID documents of the bureau staff member.
- Completed form (section 1 and 2) must be sent to the healthcare professional to complete and sign section 3 of the form.
- Once the completed form is received from the healthcare professional the bureau must email the completed form to **practice_updates@discovery.co.za**.

What must the practice owner do

- The billing practice or head of the practice must complete all fields in section 3 of the form and sign this section, only once the bureau has fully completed all other sections.
- The completed and signed form must be sent back to the bureau to continue the process.

1. Bureau details

Name of bureau	
Branch Name	
Telephone number of bureau	
Bureau email address	
Bureau manager	
Bureau manager ID number	
Bureau manager contact number	
Bureau manager's email address	
Number of staff employed at the bureau	
Number of providers you service	
Signature of bureau manager	Date D D M M Y Y Y Y

Please note: Your signature confirms that the details of the Bureau personnel provided are correct and these individuals are currently employed by the Bureau.

2. Bureau Practice personnel details

Please indicate the access to be granted using a tick (√) in the relevant box below

If **YES** is selected, the individual will have access to the HP Zone and be able to contact the call centre for general queries.

If **NO** is selected, the individual will only be able to contact the call centre for general queries with no access to HP Zone or HealthID.

Please note: Practice personnel who are granted access to the HP Zone will be able to view claims statements, benefit confirmation tools, patient clinical information, claims information, practice communication and tariff structures.

Send any future personnel changes or updates to contact details to provider_administration@discovery.co.za

Name	Surname	Contact No	Email	Healthcare Professional Zone access needed
				No
				No
				No
				No
				No
				No
				No
				No
				No
				No
				No
				No
				No
				No
				No
				No
				No
				No
				No
				No
				No
				No
				No
				No
				No

3. Healthcare professional details

Billing practice number

Practice telephone number

Practice email address

Healthcare professional name and surname

Contact number

Email address

Healthcare professional signature

Date D D M M Y Y Y Y

Disclaimer: This document, once signed by the doctor, grants the bureau the authority to add and remove staff members associated with the practice in the future. Importantly, the doctor's signature will not be necessary for these administrative actions.

Discovery

01 Annexure B: Permission to grant bureau access to practice information 2024

Please indicate the access to be granted using a tick (√) in the relevant box below.

If **YES** is selected, the individual will have access to the HP Zone and be able to contact the call centre for general queries.

If **NO** is selected, the individual will only be able to contact the call centre for general queries with no access to HP Zone or HealthID.

Please note: Practice personnel who are granted access to the HP Zone will be able to view claims statements, benefit confirmation tools, patient clinical information, claims information, practice communication and tariff structures

Send any future personnel changes or updates to contact details to provider_administration@discovery.co.za

ID number	Name	Surname	Contact No	Email	Healthcare Professional Zone access needed
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐

					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐
					Yes ☐ No ☐

Health professional signature

Date D D M M Y Y Y Y

Disclaimer: This document, once signed by the doctor, grants the bureau the authority to add and remove staff members associated with the practice in the future. Importantly, the doctor's signature will not be necessary for these administrative actions.