Association of Healthcare Funders of Zimbabwe

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For Official Use Only
Reg. Fee: $ …..…………
Rec. No: ……..…………
Payee No. ……..………..
Restrict: ……….……….

APPLICATION FORM FOR AN AHFoZ PAYEE NUMBER

Please complete in **BLOCK** LETTERS AND RETURN TO:-

The Association of Healthcare Funders of Zimbabwe, at the above address.

A registration fee of **$___________**must accompany **ALL** applications. The fee will be reimbursed/returned if the application is unsuccessful.

(i) Copies of Professional Certificates, Registration of premises and authority letter/proof of designation should be attached.

(ii) Government employees should submit documentation confirming permission to practice outside of conditions of employment.

(iii) The payee number allocated to you should not be used by any other practitioner/person other than yourself.

(iv) **In order to retain the Payee Number, the holder must renew each year before the 31st of March.**

(v) The Rules governing the use of payee numbers are obtainable from AHFoZ free of charge upon request.

(vi) Please note that officials of AHFoZ or its member societies may visit your practice premises for an inspection if they wish to do so.

1 **PERSONAL DETAILS**

1.1

Title | Initials | First Names | Surname

(Tick where applicable) Male ☐ Female ☐ ID Number

1.2(a)

Basic Registered as | Registration No.

1.2(b)

Spec/Post Basic Registered as | Registration No.

1.3

Practicing Certificate No. | Effective Date | Expiry Date

1.4

Unrestricted/Restricted to

1.5

Personal Dispensing License No. | Effective Date | Expiry Date

(if applicable)

1.6 **Employment (In a registered institution, Government, Municipal, Defense, University Services:) or any other Authority**

Are you currently employed in any capacity (In a registered institution the Government, Municipal, Defense or Universal Services?) YES NO

If yes, state (name of employer, Service/Ministry

Are you employed elsewhere other than as above YES NO

If yes, state (name of employer

1.7 **CONTACT DETAILS**

-

Postal Address

Physical Address

Telephone No.

Facsimile No.

Email Address

Cellphone No.

Skype I.D

2 **DETAILS OF PRACTICE PREMISES**

2.1.1 Name of Practice/Institution

2.1.2

HPA Premises Reg No.	Effective Date	Expiry Date

2.1.3

City Council Licensing/Accreditation of premises (if applicable)	Effective Date	

2.1.4

Premises Dispensing License No. *(if applicable)*	Effective Date	Expiry Date

2.2 **CONTACT DETAILS**

For completion by all except Nurses

2.2.1 **NB:** Practitioners not employed elsewhere are allowed to operate a maximum of two (2) surgeries/practices located within a reasonable distance from each other. The physical addresses of the practices must be stated.

Premises must be registered in your name.

2.2.2 **PRACTICE 1**

Postal Address ______________________ Physical Address ______________________

Telephone No. ______________________ Facsimile No. ______________________

Email Address ______________________ Cellphone No. ______________________

Skype I.D

2.2.3 **PRACTISE 2 *(If applicable)***

Postal Address ______________________ Physical Address ______________________

Telephone No. ______________________ Facsimile No. ______________________

Email Address ______________________ Cellphone No. ______________________

2.4 In the case of a Partnership, name(s) of other practitioners in the Partnership Practice:

1. ____

2. ____

3. ____

3 **PRACTICE DETAILS - NURSING PERSONNEL**

For completion by and in respect of ALL nursing personnel/nursing services

3.1 Area of Practice

3.2 Authority of Local Municipal/Council Authority (for midwifery practice only);

3.2.1 ________________________________

Date of Authority

FEES

4

(a) For completion in respect of ALL applications.

(b) Questions raised and answers given to be read and interpreted as being solely applicable to MEDICAL AID PATIENTS OR MEMBERS who are associates of AHFoZ.

© Where the agreed tariff of fees or applicable AHFoZ scale of awards is not accepted and adhered to, a system of direct payments by medical aid societies will not be offered or entered into.

(d) A combination of CASH and DIRECT PAYMENTS will not be accepted.

4.4 Tariff of Fees:

4.1.1 Will you be adhering to the tariff of fees agreed between service provider groups and AHFoZ and as presented in the Zimbabwe Relative Value Schedule or to the AHFoZ Scale of Awards applicable to your field of practice?

YES	No	Not Applicable

(delete what is not applicable)

4.2 Payment/Claiming Procedure:

4.2.2 Which payment/claiming procedure will you be adopting?

CASH	**DIRECT PAYMENTS FROM MEDICAL AID SOCIETIES**

(delete inapplicable)

5	**BANKING DETAILS**	
	For completion by **ALL**	
	I/We declare the Banking Details below are correct and authorize that they be used by the medical schemes and their administrators for reimbursement of claims.	
	Practice Name	
	Name of Bank	
	Name of Branch	
	Account Name	
	Branch Code	
	Account No.	
	Type of Account	
	Provider's Name	
	Authorized Signature	

6	**PREVIOUS REGISTRATION WITH AHFoZ**		
	For completion in respect of **ALL** applications		
	Have you previously been registered with AHFoZ?	YES	NO
	If YES, previous AHFoZ payee number held:		
	Reason for cancellation:		

7 **DECLARATION**

I declare that the information given in this form is correct and complete in every particular. I agree with the conditions as set out in this form.

Registration fee of $ ________________.00 attached (cheques and money orders should be crossed and be made payable to the Association of Healthcare Funders of Zimbabwe (AHFoZ).

Signature: _______________________ Date: ___________________