B·H·F
PRACTICE CODE NUMBERING SYSTEM

Board of Healthcare Funders of Southern Africa
Non-Profit Company Registration No. 2001/003387/08
Ground Floor, South Tower,
1Sixty Jan Smuts, Jan Smuts Ave, cnr Tyrwhitt Ave, Rosebank, 2196
P O Box 2324, Parklands 2121, South Africa
Tel: +27 11 537-0200
e-mail: clientservices@bhfglobal.com | web: www.bhfglobal.com
Client Services: 0861 30-20-10

Account Name:	DR SHEPHARD MAPHISA		ACCOUNT OPEN
Practice No:	014 000 1556347	Discipline:	GENERAL MEDICAL PRACTICE
Registration Date:	1997/02/19	Effective Date:	2013/07/19

Personal Details

Title:	DR	Surname:	MAPHISA
Initial:	S W	First Name:	SHEPHARD
ID/Passport No:	6102235773080	Date of Birth:	23/02/1961
Council No:	MP0440442	Gender:	MALE
Postal Address			
Address line 1:	PO BOX 4051	Suburb:	
Address line 2:		Town/City:	RIVONIA
Address line 3:		Province / Country:	SOUTH AFRICA
		Code:	2128
Contact Detail			
Telephone:	011 568 3456	E-mail:	drswmaphisa@listerclinic.com
Cell No:	083 440 1118	Preferred Communication:	E-Mail
Fax:	086 602 2789		

Practice Details

JOHANNESBURG-3RD FLOOR,LISTER MEDICAL CENTRE			
Address line 1:	3RD FLOOR,LISTER MEDICAL CENTRE	Suburb:	
Address line 2:	195 RAHIMA MOOSA STREET	Town/City:	JOHANNESBURG
Address line 3:		Province/Country:	GAUTENG
		Code:	2001
Contact No:	011 568 3456	Dispensing No:	GP03067D
Email:	drswmaphisa@listerclinic.com	Dispensing Date:	2012/06/01

Banking Details

DR SW MAPHISA PRACTICE ACCOUNT	
Bank:	FIRST NATIONAL BANK
Bank Branch:	UNIVERSAL BRANCH
Branch Code:	250655
Account No:	62754032474
Account Type:	CURRENT
Payment Method:	
Debit Order Date:	

SERVING MEDICAL SCHEME MEMBERS

DIRECTORS: Executive CM Mini(Managing), Non-Executive: A Hamdulay (Chairman), A Fourie-Van Zyl, G Goolab, I Isdale, Y Mabule, O Mahanjana, V Memela, S Motseko (Lesotho), H Nhlapo, T Nsele, C Raftopoulos, B Ramasia, S Sanyanga (Zimbabwe), H Stephens, C Schafer (Namibia), T Moumakwa (Botswana), N Nyathi, M Mahlaba.

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	Yes		No		
EDI Van	Yes	☑	No	☐	HEALTHBRIDGE
Co. Reg No	Yes	☐	No	☑	
VAT No	Yes	☑	No	☐	4740271129
Tax No	Yes	☑	No	☐	**9820530153**

I THE UNDERSIGNED, HEREBY DECLARE THAT THE ABOVE INFORMATION IS VALID AND CORRECT AND DULY AUTHORISE PCNS TO DISSEMINATE THE ABOVE INFORMATION TO PARTICIPANTS OF THE SYSTEM FOR REIMBURSEMENT PURPOSES, GEO-MAPPING AS WELL AS SHARING THE DETAILS WITH STATUTORY BODIES AND OTHER ORGANISATIONS WITHIN THE HEALTHCARE ARENA.

Partnership

Partner	Account Name	Council No	Registration Date	Personal Practice No	Dispensing License	Join Date	Effective Date
1	DR MAPHISA AND PARTNERS INCORPORATED		28/09/2015	0140000604933		28/09/2015	28/09/2015

Sub Discipline

No Sub Discipline Details Available

NAME ______________________ **DESIGNATION** ______________________

ID / PASSPORT ______________________ **DATE** ______________________

SIGNATURE ____

SERVING MEDICAL SCHEME MEMBERS

DIRECTORS: Executive CM Mini(Managing), Non-Executive: A Hamdulay (Chairman), A Fourie-Van Zyl, G Goolab, I Isdale, Y Mabule, O Mahanjana, V Memela, S Motseko (Lesotho), H Nhlapo, T Nsele, C Raftopoulos, B Ramasia, S Sanyanga (Zimbabwe), H Stephens, C Schafer (Namibia), T Moumakwa (Botswana), N Nyathi, M Mahlaba.

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Client Services: 0861 30-20-10

Please complete this form for any changes or amendments

Personal Details		
	Title:	**Surname:**
	Initial:	**First Name:**
	ID/Passport No:	**Date of Birth:**
	Council No:	**Gender:**
	Postal Address	
	Address line 1:	**Suburb:**
	Address line 2:	**Town/City:**
	Address line 3:	**Province / Country:**
		Code:
	Contact Detail	
	Telephone:	**E-mail:**
	Cell No:	**Preferred Communication:**
	Fax:	

Practice Details		
	Address line 1:	**Suburb:**
	Address line 2:	**Town/City:**
	Address line 3:	**Province/Country:**
		Code:
	Contact No:	**Dispensing No:**
		Dispensing Date:

Bank Details	
	Account Name
	Bank:
	Bank Branch:
	Branch Code:
	Account No:
	Account Type:
	Payment Method:
	Debit Order Date:
	* Please note that original verified banking details must be posted or hand delivered to the BHF offices

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EDI Van	Yes		No		
Co. Reg No	Yes		No		
VAT No	Yes		No		
Tax No	Yes		No		

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Partnership	**Part No**	**Title**	**Surname**	**Initials**	**ID/Passport No**	**Council No**	**Registration Date**	**Discipline No**	**Personal Practice No**

Name: ______________________ Date: ________________ Signature: ____________________________

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