SERVICE PROVIDER APPLICATION FORM

ADMINISTRATORS OFFICE GABORONE

Plot 54349, Ground Floor, West Wing, The Field Precinct, CBD
Premium Box 625 AAH, Gaborone
Tel: +267 316 8900
Fax: +267 316 8910

ADMINISTRATORS OFFICE FRANCISTOWN

Plot 32397, Office 26, Sunshine Plaza
Tel: +267 316 8902
Fax: +267 316 8910

BOTSWANA PUBLIC OFFICERS' MEDICAL AID SCHEME

SECTION 1 - PROVIDER DETAILS.

Thank you for your request to register as a service provider to BPOMAS members.
To facilitate a smooth registration process, please submit this completed form together with the required documentation to providerreg@bpomas.co.bw.

Provider Name	
Physical Address	
Postal Address	
Telephone Number	
Cell Number	
E-mail Address	
ID Number of Applicant	
Discipline	

SECTION 2 - BANKING DETAILS (Certified copies required)

Name of Account Holder	
Name of Bank	
Account Number	
Branch Code	

Account Type: Current/ Cheque ☐ Savings ☐

SECTION 3 - IMPORTANT DETAILS

Authorisation

- I/We hereby instruct and authorise Botswana Public Officers' Medical Aid Scheme (BPOMAS) to credit amounts, which may be due to my/our practice into the above bank account.
- I/We understand that the credit transfers hereby authorised will be processed electronically and details of each credit will be printed on my/our statement.
- In light of the above and the Data Protection Act, I hereby consent to the processing of my personal data, which includes the collection, recording, storage, gathering, use, disclosure by transmission and dissemination of such information in line with the Scheme services.

Signature of Account Holder:_____Date of Signature:_____

SECTION 4 - DOCUMENTATION REQUIRED

- ✓ Letter of authorization for private practice from Ministry of Health/Approval of licensing (Pharmacies).
- ✓ Valid registration certificate from Botswana Health Professions/Nursing Council for professional staff.
- ✓ Professional academic certificates for professional staff.
- ✓ Certificate of incorporation where a company name is provided.
- ✓ Inspection report from Ministry of Health/Drug regulatory unit will be required for clinical laboratory, radiology and pharmacy practices
- ✓ Curriculum vitae
- ✓ Certified copy of ID for all doctors in the practice.
- ✓ Original letter with original stamp from the bank (on an official letterhead) indicating the account holder's name, account number, account type and branch code which is not older than 3 months old

  OR

- ✓ Original bank statement with original bank stamp that confirms the account holders name, account number, account type and branch code which is not older than 3 months old
- ✓ If the practice name and the bank account holder name are different, please provide a Trading As Letter and CIPA documents that indicate the registration number of the company.
- ✓ If the practice has appointed an administrator, provide confirmation of the appointment on the practice letterhead together with CIPA documents of the administrator.

Please note: It will take us up to seven working days to register your practice and load your bank account detail. Please do not submit claims until you received notification from us that we have changed the bank account details.

NB: In light of the above and the Data Protection Act, I hereby consent to the processing of my personal data, which includes the collection, recording, storage, gathering, use, disclosure by transmission, dissemination of such information in line with the Scheme services.

Disclaimer:
BPOMAS Administrators will make all payments due to the healthcare provider using the banking information supplied and cannot be held liable for any loss due to incorrect banking details supplied.

SECTION 5 - COMMITMENT

In light of the above and the Data Protection Act, I hereby consent to the processing of my personal data, which includes the collection, recording, storage, gathering, use, disclosure by transmission, dissemination of such information in line with the Scheme services.

FOR INTERNAL USE:

PRACTICE NUMBER :