CAMAF
MEDICAL SCHEME
IN A CLASS OF ITS OWN

# GP NETWORK PROVIDER APPLICATION

## CAMAF NETWORK OPTIONS

**Please return the completed form to: Network.Provider@camaf.co.za**

**I agree and undertake the following:**

- ☐ I understand that registration to CAMAF network applies to the following Network options: Alliance Network, Double Network and Network Choice.
- ☐ I acknowledge and accept the **2026** negotiated reimbursement rate for **General Practitioner** consultations of **R605.99** and that CAMAF members will not be balance billed in any way, i.e., no co-payments for CAMAF members on consultations.
- ☐ Annual increases on the negotiated reimbursement rate will be according to CPI (Consumer Price Index).
- ☐ I will not charge members on Alliance Network, Double Network and Network Choice options any extra administration fees.
- ☐ Members on all other CAMAF benefit options will be charged normally and the network rate as stated above will not apply to them.
- ☐ To promote the use of generic medicines.
- ☐ Not to bill differently for the use of PMBs and non-PMBs.
- ☐ To give at least 30 days' notice when I decide to leave the CAMAF GP Network.
- ☐ I understand that, should it be necessary, members on the Network Choice option are required to use Netcare group of hospitals and members on Alliance Network and Double Network are required to use Life Healthcare and Netcare hospital groups.
- ☐ I acknowledge that my practice will take the necessary safeguards to ensure compliance with the POPI Act, such safeguards will be continuously maintained and updated to ensure that any new and potential risks are mitigated.
- ☐ I will notify CAMAF of any breaches and seek to immediately rectify the breach.
- ☐ I agree that CAMAF may display my practice contact information and address on the CAMAF website.

**Please note:** If you are registering as a Group Practice, please ensure that the individual practices registered under the Group complete the application forms as well. Alliance Network, Double Network and Network Choice members will be required to **nominate** two GPs from the CAMAF network and to only use these GPs for their GP consultations. This is done to improve care co-ordination.

## DOCTOR'S DETAILS *(Must be completed and signed by the service provider)*

| | | | |
|---|---|---|---|
| Dr's Initials & Surname | | | |
| HPCSA Number MP | | ID Number | |
| Practice Number | | Group Practice Number | |
| Physical Address | | | |
| | | | |
| | | Postal Code | |
| Postal Address | | | |
| | | | |
| | | Postal Code | |
| Practice Coordinates | | | |
| Telephone Number | | Mobile | |
| Fax Number | | | |
| Email Address | | | |

| | | |
|---|---|---|
| | | D D M M Y Y Y Y |
| Signature | Please Print Name | Date |

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