

Application to join the Momentum Health GP network/s

Please tick which GP network/s the application is for:

- Fishing Industry Medical Scheme GP Network
- Momentum Health Primary Care GP Network: Horizon Hospital Plus Network Plan; Medimed Medisave Option; Momentum Medical Scheme Ingwe Primary Care Network and Ingwe Active Network; Moto Health Care Custom and Essential Options; Pick n Pay Primary Option; Sisonke Health Diversity and Pride Legacy Options; Wooltru Network Option; Momentum Health4Me; Suremed Health Explorer and Shuttle Options
- Momentum Health GP Reimbursement Programme Agreement: BP Medical Aid Society and Momentum Medical Scheme
- Imperial Motus Medical Scheme GP Network

Do you understand and support the commitment to cost-effective treatment choices where appropriate?

Yes

No

1: Main provider's information

Practice name	<input type="text"/>																						
Main doctor's name	<input type="text"/>																						
HPCSA registration number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Individual practice number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>						
Affiliated practice number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>						
Doctor's ID number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>					
Group practice number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Indemnity insurance number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

2: Partners, associates and permanent locums' information

Please only complete this information if they are contracting to Momentum Health with the main provider.

Full name	<input type="text"/>																	
Practice number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
ID number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Full name	<input type="text"/>																	
Practice number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
ID number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Full name	<input type="text"/>																	
Practice number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
ID number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>

3: Main practice's details

Physical address	<input type="text"/>															
Suburb	<input type="text"/>	Town	<input type="text"/>													
Province	<input type="text"/>	Postal code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>										
Postal address	<input type="text"/>															
	<input type="text"/>	Postal code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>										
Practice telephone number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>						
Doctor's email address	<input type="text"/>															
Practice's email address	<input type="text"/>															
Accounts' email address	<input type="text"/>															
Practice hours	Mon – Fri	<input type="text"/>	:	<input type="text"/>	–	<input type="text"/>	:	<input type="text"/>	Sat	<input type="text"/>	:	<input type="text"/>	–	<input type="text"/>	:	<input type="text"/>
Practice manager/receptionist's name	<input type="text"/>															

4: Practice information

Do you have a dispensary?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have a computer in the consulting rooms?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have a computer at reception?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you make use of a bureau?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you make use of locums from time to time?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you work in an emergency facility?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you work on an appointment or walk-in basis? Please specify:	<input type="text"/>			
Are you or have you ever been under investigation for a complaint against you?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If yes, please specify:	<input type="text"/>			

5: Equipment and procedures information

Please indicate if you have the equipment to perform the procedures listed below at the practice:

Sonar machine	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Circumcisions - clamp method	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Lung function machine	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Circumcisions - surgical or other	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Peak flow meter	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Limb casts with plaster of Paris	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
ECG machine	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	X-ray machine in practice	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Treadmill	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Bike	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

6: Satellite practices

Do you have any satellite practices? If yes, please complete the information below.	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Address of satellite practice	<input type="text"/>				
	<input type="text"/>			Postal code	<input type="text"/>
Satellite practice telephone number	<input type="text"/>				
Address of satellite practice	<input type="text"/>				
	<input type="text"/>			Postal code	<input type="text"/>
Satellite practice telephone number	<input type="text"/>				

7: Main provider's signature

Signature	<input type="text"/>	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Please email the completed form to drnet@momentum.co.za.

Please note: Your application will be reviewed and feedback will be provided within 7 to 14 days. If successful, the relevant contract will be sent to you for your perusal.

General eligibility criteria:

- BHF registered provider
- HPCSA – active; no current investigations/judgements
- Provider not on indirect or suspended payment with any medical scheme

Momentum Health Primary Care GP Network specific eligibility criteria:

- Provider-to-member ratio
- Limited to area where members work and live
- Ingwe Active Network – close proximity to educational institutions