Supplier Information Form

Tel: 014 590 1700 | Fax: 086 760 1244 | Postal Address: Private Bag X82081, Rustenburg, 0300

Please email this form to: suppliersrpm@platinumhealth.co.za



Platinum Health requires an update on Supplier Information to ensure correct communication, remittance advices and payments.

NB: If you are a Group Practice or part of a Group Practice, please complete the Group Practice Information Form as well.

NB: PLEASE ATTACH COPIES OF THE FOLLOWING: BANK CONFIRMATION LETTER/BANK STATEMENT, BHF/PCNS FORM, ID AND PRACTICE LETTERHEAD.

NB: All the fields below are required, please make sure all are completed before submitting.

| Practice Information Section: | | | | | | |
|-------------------------------|--------------------------------|-----------------------|--------------------|---------------|-------|-------------------|
| 13th Digit Practice Number: | | | | | | |
| Name: | | | | | | |
| Registered for VAT? | YES NO | | | | | |
| VAT Registration Number: | | | | | | |
| Banking Details: | Bank Name: | | | | | |
| | Branch Name: | | | | | |
| | Branch Code: | | | | | |
| | Account Number: | | | | | |
| Postal Address: | | | | | | |
| | | | | | | ···· · |
| | | | | Code: | | |
| | | | | | | |
| Physical Address: | | | | | | |
| | | | | Code: | | |
| | | | | 3345. | ii | |
| | !····· ! ······ | T | | | | |
| Tel: | | | | | | |
| Fax: | | | | | | |
| Email: | | | | | | |
| NB: Please com | nplete the distribution method | to ensure remittances | are received after | payment runs. | | |
| Compiled by: | | | | | | ••••• |
| Date: | C C Y Y M | | | | | |
| | | | Pra | ictice S | Stamp | C |
| | | | | | | |
| | | | | | | |