METROPOLITAN
HEALTH RISK MANAGEMENT

METROPOLITAN GENERAL PRACTITIONER (GP) NETWORK
APPLICATION FORM

PLEASE COMPLETE YOUR DETAILS IN BLOCK LETTERS.

TO BE COMPLETED BY APPLICANT

Full name

Surname

Identity no.

Practice no. (BHF) (This is the practice number under which you normally send accounts.)

IPA group

HPCSA no.

Indemnity insurance no.

CONTACT DETAILS

Physical address

Suburb

Town

Province Code

Postal address

Code

Telephone (H) (W)

(Fax) (Cell)

Email address

APPLICANT'S CONSENT

I hereby confirm my agreement to me and my practice being appointed as a Contracted Provider by Metropolitan Health Risk Management (Pty) Ltd, and that I have read and understand the **terms and conditions** posted on their website at www.qualsa.co.za.

Signature _____ Date Y Y Y Y M M D D

Please fax back to 021 480 2733 or email to networks@mhg.co.za

Please complete a separate form should you have more than one practice address.