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# Application Form:

Accreditation and Renewal as a Managed Health Care Organisation

(For use by managed health care organisations in terms of Chapter 5 of the Regulations to the Medical Schemes Act.)

\*This form is also available on the Council’s website:[**www.medicalschemes.com**](http://www.medicalschemes.com)

Applicants are requested to send the required information to:

|  |  |
| --- | --- |
| **Postal Address:**  Mr Danie Kolver  General Manager: Accreditation  Council for Medical Schemes  Private Bag X34 **HATFIELD**  0028 | **Delivery address:**  Block A, Eco Glades 2 Office Park  420 Witch-Hazel Avenue  **CENTURION**  0157  **Email address:**  d.kolver@medicalschemes.com |
| **Enquiries:**  Ms Belinda van der Walt  Tel: 012 431 0510  Fax: 086 682 9646  E-mail: [b.vdwalt@medicalschemes.com](mailto:b.vdwalt@medicalschemes.com) | **Enquiries**:  Ms Hannelie Cornelius  Accreditation Manager: Administrators and MCOs  Tel: 012 431 0406  E-mail: [h.cornelius@medicalschemes.com](mailto:h.cornelius@medicalschemes.com) |

# SECTION A: To be completed by all applicants

1. Full name of managed healthcare organisation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Company registration number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. State the translated, abbreviated name, trading name or derivative, if any, of the name in

question 1.

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| --- | --- |
| a) Translated: | b) Abbreviated: |
| c) Trading name: | d) Derivative: |

1. Particulars of the head office of the applicant managed care organisation:

(a) Physical address: (b) Postal address:

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(c) Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(d) Website address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(e) Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (f) Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. State names, identity numbers and nationality of directors:

Name: ID Number: Nationality:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Questions 6 to 13 below refer to the person who is the Chief Executive Officer (CEO) of the managed care organisation:

(Note that a *curriculum vitae* must be supplied for this person.)

(If the CEO is not the same person as the head of the company’s managed care business kindly also complete Questions 14 – 21)

1. Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Identity no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Postal address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Telephone no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Office) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Home)
7. Cell no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Questions 14 to 21 below refer to the person who is the head of the company’s managed care business:

(Note that a *curriculum vitae* must be supplied for this person.)

1. Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Identity no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Postal address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Telephone no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Office) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Home)
7. Cell no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. E- mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. State the financial year end of the applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Names of the audit firm appointed by the applicant and the responsible partner at the firm:

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1. Provide a brief description of the managed health care service(s) provided / to be provided (Please refer to Circular 13 of 2014 for the accreditable managed health care services):

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1. Indicate whether services are provided in terms of a capitation fee arrangement in respect of risk/risks transferred in terms of the contract, a fixed fee per member or beneficiary per month, a standard fee or a combination of any of the above:

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1. Provide details of any re-insurance undertaken by the applicant:
2. Name of re-insurer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. The extent of cover re-insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Duration of agreement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Copy of re-insurance agreement to be attached.
3. Supply the names of all medical schemes with whom the organisation has contracted / will contract with to provide managed care services (*note that copies of the latest signed agreement/s, including all subsequent addenda must be supplied*) and list the current year fees per service per scheme/benefit option:

|  |  |
| --- | --- |
| Scheme name | Fee per service provided |
|  |  |
|  |  |
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1. Supply the names of all medical scheme administrators with whom the managed care organisation has contracted to provide managed care services (*note that copies of the latest signed agreement/s, including all subsequent addenda, must be supplied*) :

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1. Supply the names of all other persons or entities with whom the applicant has contracted or

sub-contracted to provide outsourced managed care services (*note that copies of the latest signed agreement/s, including all subsequent addenda, must be supplied*) :

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1. Supply full details (name, nature of interest / relationship, etc.) of all entities in which the applicant has a financial interest and/or with whom the applicant has a related party relationship (“related party” as defined in IAS 24), including any of the following:
2. an administrator of medical schemes;
3. a broker organisation;
4. another managed care organisation;
5. a group of health care providers;
6. any other organisation which provides health care services to medical schemes;
7. a short or long term insurance company or a re-insurer.

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1. Provide full details of shareholding in the applicant:

|  |  |
| --- | --- |
| Organisation/Individual | % Shareholding |
|  |  |
|  |  |
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1. Provide a brief description of the main business of the persons / entities in question 31:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Attach a copy of the detailed group structure of the group to which the applicant belongs, clearly indicating the respective shareholders (and percentage shareholding) in each, as well as the directors of each entity.
2. Indicate what other business, if any, apart from managed health care services, is / will be conducted by the applicant:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# SECTION B: To be completed by applicants applying for renewal of accreditation as a managed care organisation

The following information relates to the period from the previous accreditation evaluation up to the date of the renewal application:

1. Provide details of any changes in shareholding as well as the effective date of the changes:

(a) in the applicant:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(b) by the applicant in other entities:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Provide details of any changes in the group structure of the applicant, as well as the effective date of such changes:

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1. Provide details of any changes to the managed health care, financial and other systems. (Indicate what was changed, when it was done and why it was done):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Provide details of any changes in senior management within the organisation and the impact of such changes on the applicant’s business in terms of availability of skills and expertise :

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Provide details of any changes in the nature and/or extent of the managed health care services provided:

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1. Provide details of any changes in the outsourced services to other parties:

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1. I hereby enclose the following documents:
2. A copy of the detailed group structure to which the applicant belongs (Question 33).
3. A curriculum *vitae* in respect of the Chief Executive Officer and the head of the managed care organisation’s business (Questions 6 and 14).
4. Latest signed copies, including all subsequent addenda, of all managed care agreements or proposed agreements between the managed care organisation and medical schemes (Question 27)
5. Latest signed copies, including all subsequent addenda, of all agreements with medical scheme administrators and other entities to provide managed care services (Question 28).
6. Latest signed copies, including all subsequent addenda, of all sub-contracting agreements between the managed health care organisation and any other entity (Question 29).
7. Copies of the latest audited annual financial statements and most recent management accounts (Balance Sheet and Income Statement) with notes thereto.
8. Certificate of good standing from the South African Revenue Service.
9. Copy(ies) of any re-insurance agreement(s). (Question 26).
10. The completed self-evaluating questionnaire, available on our website [www.medicalschemes.com](http://www.medicalschemes.com) (Only if an on-site evaluation of the organistion’s compliance with the managed care accreditation standards **has not** yet been conducted).
11. Proof of payment of the **non-refundable application fee** as prescribed for accreditation as a managed health care organisation. (Kindly refer to Regulation 31 of the Regulations to the Medical Schemes Act, 1998)

Please note that the application fee has increased to R14 000 with effect from 2 September 2016. (Banking details are provided below)

1. Please provide a copy of the organisation’s current B-BBEE certificate if available (for statistical purposes only).

Declaration by head of the applicant organisation:

1. I declare that, to the best of my knowledge, the information supplied herein is complete, true and correct and not misleading in any respect.

2. I hereby confirm that I have the necessary authority to furnish this information and to make the undertakings required herein.

3. I undertake to supply any further information requested by the office of the Registrar, or the Council for Medical Schemes, as and when required for purposes of carrying out the provisions of the Medical Schemes Act, 1998 and regulations published thereunder.

Signature Date

**Full names: (Please print) Designation**

COUNCIL FOR MEDICAL SCHEMES: BANKING DETAILS

Bank : ABSA

Branch : ABSA Corporate Branch

Branch Code : 517245

Account number : 4051 163 394

Reference : \*Accreditation number (as indicated on the accreditation certificate)

\* If a new applicant, provide the name of the organisation as reference