BEST med
medical scheme

GENERAL PRACTITIONERS REMUNERATION ARRANGEMENT

between

BESTMED MEDICAL SCHEME (Hereinafter referred to as **BESTMED**)

and

DR____

MEDICAL DISCIPLINE___________________________________ **PRACTICE NR**_________________________

(Hereafter referred to as the **SERVICE PROVIDER**)

BESTMED OFFERS TO THE SERVICE PROVIDER THAT

1 **Bestmed** shall pay the **Service Provider** the following tariffs for medical services rendered to beneficiaries of **Bestmed** during 2010:
  - **1.1** For consultations (Codes 0190, 0191, 0192): R 256.50, and
  - **1.2** For all other procedures and services: Not more than the National Health Reference Price List (2009) + 10.5%.

2 **Bestmed** shall pay all valid accounts of the **Service Provider** directly into his/her nominated bank account within 14 (fourteen) days of receipt of the accounts.

3 Incorrect payments made by **BESTmed to the Service provider,** which are older than 30 (thirty) days, shall not be offset against payment due to the **Service Provider.**

4 The tariffs payable in terms of this arrangement shall only be valid for 2010 and shall be reviewed for succeeding years with written notice to the **Service Provider** of any adjustments made.

ON THE FOLLOWING CONDITIONS

1 The **Service Provider** shall only charge the tariffs as specified in clause 1 above.

2 The **Service Provider** shall not recover any amount from any **Bestmed** beneficiary in respect of any medical service rendered to that beneficiary including co-payments, levies, administration fees and/or deductibles, except in respect of services for which no benefits are available.

3 The **Service Provider** shall submit all accounts electronically to **Bestmed.**

4 This arrangement shall become effective upon receipt by **Bestmed** of the signed arrangement from the **Service Provider** at the address nominated under 5.1 below.

5 This arrangement can be terminated by any party with 30 (thirty) days' written notice to the other party at the following addresses selected as *domicilium citandi et executandi:*

5.1 **Bestmed**
Address: (Postal)PO Box 2297, Pretoria, 0001 Fax: (012) 339 9443

5.2 **Dr** ____

5.3
Postal address: ____

Tel: (_______)______________________________________Fax:(______)______________________________

6 This arrangement shall be automatically terminated should the **Service Provider** breach any condition and/or other term of this arrangement.

I, THE UNDERSIGNED SERVICE PROVIDER ACCEPT THE ABOVE OFFER OF BESTMED AND NOMINATE THE FOLLOWING BANK ACCOUNT FOR PAYMENT OF MY ACCOUNTS BY BESTMED, WHICH ACCOUNT DETAILS MAY BE CHANGED WITH 7 (SEVEN) DAYS' WRITTEN NOTICE TO BESTMED:

Bank______________________________ **Branch**________________________ **Branch Nr**___________________

Name of Account Holder ____________________________________ **Account Number**______________________

Signed on ________________________________200__ at ____

Signature of Service Provider: ____

Signature of Witness: ____

PLEASE COMPLETE AND FAX TO : (012) 339-9443.