



## Practice bank details form for Electronic Funds Transfer (EFT)

Dental Information Systems Pty (Ltd) (DENIS) on behalf of our medical scheme clients provides payment for claims where applicable. We require your recent banking details in order to do these payments via bank transfers.

### Please note:

- Payments are made weekly and only via EFT to the registered banking account.
- DENIS has phased out all cheque payments.

### What you need to do:

- Fill in the form and print clearly, or complete the form digitally with the Adobe Fill & Sign tool
- To avoid administration delays, please make sure this form is completed in full
- Once it is complete, fax the form to **086 677 0336** or email it to [thenetwork@denis.co.za](mailto:thenetwork@denis.co.za) or via post to DENIS, PO Box X1, Century City, 7446
- You need to submit the following documents with this form:

#### A) When the banking details (practice or private) are in your name -

1. Proof of the account – a cancelled cheque/stamped bank letter that is not older than **3 (three) months** or a stamped copy of a recent bank statement not older than **3 (three) months**
2. A clear copy of the account holder's identity document (ID), passport or driver's licence

#### B) When using a company or third party account -

1. Proof of the account – a cancelled cheque/stamped bank letter that is not older than **3 (three) months** or a stamped copy of a recent bank statement not older than **3 (three) months**
2. A clear copy of the identity document (ID), passport or driver's licence of each signatory or person who has authority to sign on behalf of the company
3. A letter of authority including the details (*names and contact details*) of all persons of authority as well as the provider's details
4. A copy of the company's certificate of registration

Dental Information Systems (Pty) Ltd

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Reg no: 1996/000371/07

[www.denis.co.za](http://www.denis.co.za)

Directors: PAP Leroy, DC Carolus, HL Nhlapo

Practice Name					
Practice Number					
<b>Practice</b> Physical Address			<b>Admin Company</b> Physical Address		
<b>Practice</b> Postal Address			<b>Admin Company</b> Postal Address		
<b>Physical Practice</b> Telephone Number			<b>Admin Company</b> Telephone Number		
<b>Practice</b> Fax Number			<b>Admin Company</b> Fax Number		
Cell Number			<b>Admin Company</b> Cell Number		
<b>Practice</b> Email Address			<b>Admin Company</b> Email Address		
Practice Account Name					
Practice Bank Name					
Account Number					
Account Type (Tick appropriate box)	Current account	<input type="checkbox"/>	Savings account	<input type="checkbox"/>	Other

**Telephonic verification will be done for security purposes.**

I/we hereby, instruct and authorise you to pay my/our medical scheme refunds which may accrue to me/us to the credit of my/our account with the above-mentioned bank (or any bank or branch to which I/we may transfer my/our account).

Signed: \_\_\_\_\_ at \_\_\_\_\_ on \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Print Name: \_\_\_\_\_