Practice Billing

Kindly complete questionnaire below in order for us to provide you with an accurate quotation / feedback

All your information provided will be handled confidentially and will not be used for any other purposes and will be used in accordance with POPIA

Healthcare Professional Name

Practice Number

Speciality Type

City / Province

Approximate Monthly Turnover

Email Address

Contact Number

Additional Request / Information

Practice Billing

Kindly tick the services your practice requires below (Yes/No)

		Yes	No
1	Contact patients prior to procedures to discuss practice rates and obtain signed consent forms.	☐	☐
2	Securely file and maintain all relevant documents, including billing forms, patient information, and reports.	☐	☐
3	Obtain Payment guarantees (GOP's) from international insurers prior to procedures & Obtain payments from private patients prior to medical procedures.	☐	☐
4	Provide cost estimates to patients in accordance with your practice's guidelines and agreements.	☐	☐
5	Guidance on medical aid contracts and payment arrangements, including strategic advice on potential partnerships to improve turnover.	☐	☐
6	How would you submit your billing ? (Email, WhatsApp or Courier)	E-Mail	

Kindly email the completed questionnaire to :

info@mypracticesa.co.za