

### CHANGE OF BANK ACCOUNT DETAILS: SERVICE PROVIDERS

Name of Provider

Practice No.

#### CONTACT DETAILS

Practice Physical

Address

Code

Postal Address

Code

Telephone No.

Cell

Fax No.

Email

#### NEW ACCOUNT DETAILS

Effective Date

Account Holder

Name of Bank  Branch Code

Name of Branch

Account No.

Type of Account  Cheque  Savings  Transmission

NB: For purposes of verification please attach a copy of your ID, copy of a cancelled cheque and / or most recent original bank statement or letter from your bank.



#### Full name and surname of person completing the form:

Full Name

Surname

Designation

#### OFFICE USE ONLY

Instruction updated on Administrative System		YES	NO
Phoned and confirmed bank account details with			
<input type="text"/>			
On			
<input type="text"/>			
Requested		Approved	
<input type="text"/>		<input type="text"/>	
 <small>Global Health Solutions</small>		 <small>RESOLUTION health Medical Scheme</small>	

Please fax this form back to:

Attention: Provider Relations Department  
 Fax No: 086 605 9440  
 Email: info@agilityghs.com  
 Tel: 0861 796 6400

I hereby authorise Resolution Health Medical Scheme to change the above stated bank account details

Signed at \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_ / \_\_\_\_\_

SIGNATURE

Signature of Provider

Trustees: Dr. N.B. Mabuya (Chairperson), Mr. M.N. Coetzee CA(SA) (Vice-chairman), Dr. D.E. Lekalakala, Dr. J.C. Jansen, Mr. S.P. Mohale, Mr. J.G. Appelgryn CA(SA)  
 Principal Officer: Mr. M.D. Arnold

Adminstrated by