CLAIM FOR SICKNESS BENEFIT- DECLARATION BY DOCTOR FOR CLAIM RELATED TO COVID-19 (CORONAVIRUS) EXPOSURE OR INFECTION

IMPORTANT To be completed by the treating Medical Doctor only.

Please answer all the questions in full to ensure a timeous and complete assessment of the patient's claim. PPS obtained prior written consent from the life insured in terms whereof additional information pertaining to the claim may be provided. All medical information will be treated according to the ASISA guidelines on Confidentiality of Medical Information.

Please fax the fully completed form and supporting documentation to PPS Claims 011 644 4520 or email claims@pps.co.za

NOTE: The PPS Claims Protocol for COVID-19 is available on the PPS website: pps.co.za/covid-19-coronavirus

PART A: PARTICULARS OF PATIENT

Surname: Initials:

Date of birth: D D / M M / Y Y Y Y

PART B: PARTICULARS OF CLAIM

Consultation date: D D / M M / Y Y Y Y

Primary Diagnosis:	Date made:	ICD 10 code:
Secondary Diagnosis:	Date made:	ICD 10 code:

Presenting/Reported Symptoms (complete only if applicable):

Date of onset of symptom/s: D D / M M / Y Y Y Y

Date symptom/s ended: D D / M M / Y Y Y Y

Fever (>38^{0}C)		Anosmia - loss of sense of smell		Cough		Sore throat		Weakness	
Vomiting		Dysgeusia - alteration of sense of taste		Body pains		Shortness of breath		Diarrhoea	

Other (please specify if applicable):

Was the patient hospitalised with severe acute respiratory illness AND was there no alternative diagnosis for the clinical presentation? (attach evidence of hospitalisation) YES ☐ NO ☐

Date of admission: D D / M M / Y Y Y Y

Date of discharge: D D / M M / Y Y Y Y

Details of treatment administered for current illness (complete only if applicable):

Name of medication/ therapy	Dose and frequency of treatment	Date commenced	Completion date

Is the patient compliant with the treatment prescribed? YES ☐ NO ☐

If not, provide comprehensive details when treatment was stopped and / or alternative treatment provided:

Provide **details of complications** in addition to the above which prolonged this incapacity beyond what can be reasonably expected for a condition of this nature?

Please provide details of **pre-disposing risk factors** known to you, e.g. any chronic condition, immunocompromised state, immune-suppressive therapy, etc.

Testing for COVID-19:

Was the patient tested for COVID-19? YES ☐ NO ☐

Date/s of sample collection

If tested Positive, date of first Positive test result; D D / M M / Y Y Y Y

If tested Negative,

Date of first Negative test result; D D / M M / Y Y Y Y ;

Date of Second Negative test result; D D / M M / Y Y Y Y

If tested, **attach copies** of all tests results.

Exposure to a Confirmed case of COVID19:

Question	**Yes**	**No**	**Unknown**
Was the patient in close contact with a **confirmed** case of COVID-19?	☐	☐	☐
Question	**Yes**	**No**	**Unknown**
Does the patient have a history of travel outside of South Africa or country or permanent residence?	☐	☐	☐
If yes, provide details (countries visited and dates of travel).			

Question	**Yes**	**No**
Did the illness originate outside a Southern African Development Community country (SADC)?	☐	☐
If yes, state which country:		

Question	**Yes**	**No**	**Unknown**
Does the patient work in, or has the patient worked in or attended a health care facility where patients with COVID-19 infections are being treated?	☐	☐	☐
If yes, provide details (name of facility, reason for attendance, dates).			

Information regarding isolation or quarantine:

Was the patient advised to isolate or quarantine? YES ☐ NO ☐

Please state by whom the patient was advised to isolate or quarantine? _____

Important: Attach a **copy of the instruction** to isolate or quarantine; if available to you

Self	☐	Employer	☐	Government Authority	☐
National Institute for Communicable Diseases	☐	Medical Practitioner	☐	Other (specify)	☐

Date of start of isolation or quarantine: D D / M M / Y Y Y Y

Date of end of isolation or quarantine: D D / M M / Y Y Y Y

Recommended Claim dates: (sickness period and isolation or quarantine period)

TOTAL BENEFITS: The patient was unable to perform **ANY** professional duties:

From: D D / M M / Y Y Y Y To: D D / M M / Y Y Y Y

NOTE To qualify for Total benefits your patient should not be able to perform any of the occupational duties normally associated with their above occupation, whether physical or mental tasks, including minor physical tasks such as consulting, or administrative tasks such as dealing with queries.

PARTIAL BENEFITS: The patient was able to perform some of their professional duties

From: D D / M M / Y Y Y Y To: D D / M M / Y Y Y Y

NOTE To qualify for Partial benefits your patient is able to carry out some of their normal occupational duties as above, or work reduced working hours compared to normal working hours, but not all. PPS Claims will also assess this in line with the occupation and profession.

When did your patient resume his / her usual professional duties on a full-time basis?

D D / M M / Y Y Y Y

If your patient has not returned to work, please indicate the expected return to work date

Full time: D D / M M / Y Y Y Y Part time: D D / M M / Y Y Y Y

PART C: MEDICAL PRACTITIONER'S DETAILS

HPCSA Reg No: | | | | | | | | | | | Practice No: | | | | | | | | | | |

Surname: | | | | | | | | | | | | | | | | | | | | Initials: | | | | | |

Telephone No: | | | | | | | | | | | Fax No: | | | | | | | | | | | | | |

Email Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | | | | | | | |

Signed at _____ this _____ day of _____ 20 _____

Signature of medical doctor: _____