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

The Professional Provident Society Holdings Trust No IT 312/2011 (PPS) is a Registered South African Trust. The Professional Provident Society Insurance Company Limited Reg. No 2001/017730/06 (PPS Insurance) is an Authorised Financial Services Provider – License No. 1044

Note : *This form should only be completed by the Medical Doctor who attended to the claimant in the period claimed for.*

IMPORTANT

1. All medical information will be treated according to the ASISA guidelines on Confidentiality of Medical Information. Any costs incurred in obtaining the supporting document/s will be for the life Insured's account.
2. **PPS Claims Contact details:**
   e-mail: claims@pps.co.za
   Fax: 011 644 4520
   Queries
   e-mail: memberservices@pps.co.za
   Tel: 011 644 4300

COVID-19 Related Sick Leave Claim Requirements

Topic		Requirements and notes
A	**All types of COVID claims**	• Copy of COVID test result • Declaration by Member Claim Form • Declaration by Doctor Claim Form PPS Insurance aims to pay all valid claims timeously. Accurately completed forms facilitate the assessment process and allows for a correct assessment. Please read the **PPS Claims Protocol for COVID-19, available on the PPS website** (pps.co.za/covid-19-coronavirus), before completing this form.
B	**Claim duration**	
1	**10 days or less**	As noted in **A** above Most people who contract COVID-19 are asymptomatic or have mild symptoms that will not prevent them from working remotely. This is especially evident once vaccinated. Some people however suffer moderate to severe symptoms that prevent them from performing some or all of their usual professional duties. People who contract COVID-19 generally recover sufficiently to resume work duties within 10 days.
2	**Exceeding 10 days**	• **In addition to A above, a medical report** that include copies of all relevant medical, blood and special investigations undertaken. • Any other relevant documentation **to justify the need for extended recovery**. Refer to the **attached addendum for a set of specific requirements** to substantiate **extended claims.**
C	**COVID complications**	• A **detailed breakdown of the complications and a medical report** that include copies of all relevant medical, blood and special investigations undertaken. • Any other relevant documentation, **to confirm the complications and substantiate the need for extended recovery.** Refer to the **attached addendum for a set of specific requirements** to substantiate **extended claims.**
D	**Long COVID**	• Beyond the initial period of infection, claims should be submitted to PPS monthly. • Claim forms should be signed and submitted after the period claimed for, as claims cannot be assessed prospectively.

PART A: PARTICULARS OF PATIENT

Member number:

Surname: Initials:

National ID number : Cellular:

Medical aid name: Medical aid number:

Email address :

PART B: PARTICULARS OF CLAIM

First Consultation date: D D M M Y Y Y Y

Follow up consultation dates:

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

Details of presenting symptoms of the **disease/condition that significantly prevented** your patient from **performing** his/her **usual professional duties and required optimal medical treatment or supervision** such as: **medication, hospitalisation, surgery or rehabilitation:**

Symptom description Start date and end date	**Details of treatment/ rehabilitation**	**Treatment commencement and end date**	**Details of treating practitioner** (Name and contact number)
E.g. Fatigue and brain fog 15/08/2021 to 30/08/2021	*E.g. Occupational therapist for paced return to work*	*E.g. 16/08/2021 to 30/08/2021*	*E.g. Ms. X*
dd/mm/ccyy to dd/mm/ccyy		dd/mm/ccyy to dd/mm/ccyy	
dd/mm/ccyy to dd/mm/ccyy		dd/mm/ccyy to dd/mm/ccyy	
dd/mm/ccyy to dd/mm/ccyy		dd/mm/ccyy to dd/mm/ccyy	
dd/mm/ccyy to dd/mm/ccyy		dd/mm/ccyy to dd/mm/ccyy	
dd/mm/ccyy to dd/mm/ccyy		dd/mm/ccyy to dd/mm/ccyy	

Did the patient require admission to hospital? YES ☐ NO ☐

Name of Hospital:

Date of admission: YES ☐ NO ☐

Date of discharge: YES ☐ NO ☐

Admission to Intensive Care Unit (ICU) YES ☐ NO ☐ D D M M Y Y Y Y

Admission to High Care Unit YES ☐ NO ☐ D D M M Y Y Y Y

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 complication/s** 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 **comorbidities and indicate how it influenced your patient's recovery, where applicable**.

Testing for COVID-19:

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

If the primary or secondary condition noted above is COVID-19 but tests were negative, kindly clarify.

Kindly attach copies of all test results (if available).

Date of sample collection	Type of test e.g. PCR, antibody test, rapid antigen test.	Result	Result Date

Recommended sick leave periods:

TOTAL sick leave: 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, remotely or at place of work.

PARTIAL sick leave: 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, remotely or at place of work. 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**:

Partial bases: D D M M Y Y Y Y **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

Part time: D D M M Y Y Y Y **Full time:** D D M M Y Y Y Y

PART C: TREATING DOCTOR/ SPECIALIST BANKING DETAILS

EFT Medical Payments form

Note: Doctors submitting invoices for payment with PPS Insurance for the need to include the following documents.

- Certified copy of doctors identity document
- Company registration copy used to open the account, if the doctor is part of a medical practice under incorporation.
- Bank letter with the original stamp not more than three months old and
- The completed EFT Medical Payments form below

Please fax back to 011 644 4530 or email to medpayment@pps.co.za

Policy number:

Surname:

Initials: ID Number:

PPS Reference:

Email Address:

Banking details for Electronic Payment:

Name of Bank:

Branch Code:

Account Holder:

Account Number:

Types of Account: Cheque: Savings

Company Registration number

Indemnity: Please take note that PPS will not be held liable for incorrect payments, if the information received is incorrect.

I certify that all the above information is correct.

HPCSA Reg No: Practice No:

Signed at (Place): on this day of 20

Signature of doctor:

ADDENDUM TO DECLARATION BY DOCTOR FORM – ONGOING CLAIM RELATED TO COVID-19 (CORONAVIRUS) INFECTION

To effectively manage your patient's Long COVID claim, you may have performed any one or a combination of the tests/evaluations listed below. The test results will assist PPS in performing a holistic assessment of your patient's condition and the affect thereof on his/her ability to work. Any costs incurred in obtaining the supporting document/s will be for the life Insured's account.

Please attach a copy of all the test results, where applicable.

Note: 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.

REQUIREMENTS TO HOLISTICALLY ASSESS LONG COVID-19 CLAIMS

COMPLICATION	TEST/INVESTIGATION
Fatigue, Brain fog, PTSD, Anxiety, Depression	• Blood tests FBC, U&E, Vitamin B 12, Thyroid, ESR, CRP, D-Dimer, IL-6 etc • Imaging e.g. MRI brain, CT scan • Functional assessment/report from rehabilitation health care provider • Cognitive screening • Mini Mental Status Examination(MMSE) • Montreal Cognitive Assessment (MoCA) • Beck depression inventory • Exercise tolerance test
Heart Failure Arrhythmia Acute coronary syndrome including Myocardial infarction Myocarditis Pericarditis	• Blood tests: Pro BNP, cardiac enzymes, FBC, ESR • METS • 6 min Walk test • ECG- stess or resting • Echocardiogram • Imaging e.g. MRI, Biopsy or Angiogram • Nuclear medicine scan
Guillain-Barre Transverse Myelitis Stroke Peripheral Nerve damage Hypoxic brain damage	• Blood tests: U&E, LFT, ESR, Creatinine Phosphokinase levels • Lumbar-puncture results • Nerve Conduction studies • Imaging e.g. MRI, CT scan • EMG • Functional assessment
Acute Renal Injury Chronic renal failure Chronic Kidney dysfunction Post COVID-19 Renal/Urinary system	• Blood tests: U&E, eGFR, Hb • Urine Protein levels (24-hr. creatinine, Protein Creatinine ratios) • Renal imaging e.g. ultrasound, Kidney biopsy (where applicable)

Diabetes Mellitus	• Blood tests: HbA1C, U&E, Cholesterol
Liver abnormalities	• Blood tests: LFT should include: GGT, Bilirubin, Albumin and U&E • Ascitic fluid analysis • Liver Biopsy • Imaging studies • Child-Pugh assessment score
Pulmonary fibrosis Pulmonary embolism Interstitial lung disease Acute respiratory distress syndrome (ARDS) Microvascular COVID – 19 lung vessels Obstructive thrombo-inflammatory syndrome	• Blood tests: Arterial Blood gases Oxygen Saturation levels on discharge • CT scan • Copy of report if a Lung biopsy was done • Latest Pulmonary function test (PFT) • Chest x-ray • Cardiac assessment • Functional assessment/report from rehabilitation health care provider