CLAIM FOR SICKNESS BENEFIT (DECLARATION BY MEDICAL DOCTOR / DENTIST)

NOTE To be completed by the treating Medical Attendant only.
Please answer all the questions in full to ensure a timeous and complete assessment of your patients 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 to PPS Claims 011 644 4520 or email claims@pps.co.za

PART A: PARTICULARS OF PATIENT

Surname: Initials:

Date of birth: (dd/mm/yy): D D / M M / Y Y Y Y Occupation prior to the sickness:

PART B: CLAIM DETAILS

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

Start date: D D / M M / Y Y Y Y **End date:** 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.

2. **PARTIAL BENEFITS:** The patient was able to perform **SOME** professional duties from:

Start date: D D / M M / Y Y Y Y **End date:** 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.

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

D D / M M / Y Y Y Y

4. 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: PARTICULARS OF DIAGNOSIS, CONSULTATIONS
Please attach copies of all relevant investigations in support of the claim.

Diagnosis: Primary Diagnosis:	Initial date made:	ICD 10 code:
Secondary Diagnosis:	Initial date made:	ICD 10 code:

5. Did the condition have: an acute onset? ☐ Slowly progressive onset? ☐

6. Provide date of **initial consultation** and brief details of the **chronological history** of the condition, or sequence of events:

7. Date(s) of **follow-up consultations**:

8. Which **side of the body** is affected? Left: ☐ Right: ☐ Both: ☐ Not applicable: ☐

9. If affected, is it a dominant limb? YES ☐ NO ☐

10. Is this claim due to an **injury or traumatic event**? YES ☐ NO ☐

11. If YES date of injury or event: D D / M M / Y Y Y Y

Please provide details in this regard (motorcycle accident, rugby injury, hijacking incident, etc.)

PART D: PARTICULARS OF TREATMENT; RESPONSE TO TREATMENT AND ANTICIPATED FURTHER TREATMENT

12. Was any **surgery / procedure** performed? YES ☐ NO ☐

Date of Surgery/Procedure: D D / M M / Y Y Y Y

If yes, provide details:

Nature of surgery: Open Surgery: ☐ Laparoscopic Surgery: ☐

Were there **any complications** following surgery?

Is **additional surgery/procedure** anticipated? If yes, provide details (i.e. dates, nature of surgery):

13. **Details of treatment** administered for current illness or claim event including medication, physiotherapy and psychotherapy :

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

14. Is/has the **patient been compliant** with any treatment prescribed? YES ☐ NO ☐

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

15. 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?

16. Provide **details of Pre-disposing risk factors** e.g. raised cholesterol, hypertension, alcohol abuse which may have led to the development of this illness or claim event:

PART E: GENERAL

17. Is it possible that this diagnosis might result in any form of **permanent incapacity**? YES ☐ NO ☐

If yes, please provide details?:

18. Are you related to this patient? YES ☐ NO ☐

If yes, please provide details?:

PART F: 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:

INFORMATION REGARDING THE DECLARATION BY MEDICAL DOCTOR/DENTIST FORM

PPS takes into consideration the standard recovery time for which any particular illness would, under normal circumstances, reasonably render a person unable to perform his/her professional duties. The standard recovery time is based on current clinical practice and research into relevant medical literature regarding treatment protocols and anticipated recovery periods. PPS will, however take into consideration aggravating factors influencing the recovery of the individual, when assessing a claim. In this regard, please provide relevant medical information which will assist PPS in its assessment of the claim.

Claims for sickness benefits must be made on the prescribed PPS claim forms.

Please note the following:

1) The treating medical practitioner / dentist must complete this form. Please note that PPS does not accept telephonic consultations and the policy rules require that the claimant should be personally examined by the attending medical practitioner.
2) The member must have consulted the treating medical practitioner within the first 7 days of the start of the claim period and the most recent consultation dates should be stated.
3) The Declaration by Medical Doctor / Dentist Form should cover the whole period claimed for. No post-dated forms will be accepted, except in the cases where PPS has authorised such request. PPS may, at its discretion, request weekly or monthly declarations to confirm diagnosis, treatment and progress.
4) In order to avoid conflict of interest, PPS will not allow Declaration by Medical Doctor/ Dentist Forms to be signed by practitioners where there is a familial or other relationship between the physician and the policyholder except for the doctor/patient relationship. Where this is not the case PPS reserves the right to ask for any additional medical or other information that it may deem necessary in order to validate the claim.
5) Please note that whilst PPS values the contribution of psychologists, physiotherapists and occupational therapists in the treatment of patients, only medical doctors may book PPS members off work for PPS benefits.
6) In determining whether the patient is booked off as 'Total' or 'Partial', please indicate on the form if the patient can perform any of his/her usual professional duties. Usual Professional Duties are defined as those occupational tasks which the patient is required to carry out as part of his/her occupation prior to claim. This may include administrative duties or tasks such as attending to electronic communication
7) No fee(s) will be paid by PPS for the completion and/or submission of this form. If you intend to levy a fee for the completion and/or submission of this form payment will have to be discussed and arranged directly with your patient.
8) PPS reserves the right to request further reports or consultation records should the need arise.

For further information please ask your patient to consult the PPS How to Claim Document and their PPS Provider Policy.