PPS DISABILITY CLAIM FORM- MEDICAL DOCTOR

This form applies to the PPS Professional Provider™ Disability Insurance (DISA), Professional Disability Provider™ (PDP) and PPS Life Assurance with Accelerated Disability.

Dear Doctor,

We appreciate your time and cooperation to assist us in considering a Disability claim for your patient.

The following is important:

- PPS Insurance (Namibia) has signed consent from your patient to obtain confidential medical information from you.
- In addition to this form, PPS will require a comprehensive medical *report.
- Any cost to provide this information will be for your patient's account.
- **Please send the completed form and supporting documents to:**
    - Fax: +264 (0)61 411 330, or
    - E-mail: namibiaclaims@pps.co.za
- Your prompt response will be appreciated.

**Report guidelines provided at the back of this form.*

PART A: MEMBER DETAILS

Member Number: National ID Number:

Surname: Initials:

Occupation prior to disability:

PART B: MEDICAL CONDITION

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

PART C: MEDICAL REFERRALS

Please provide the details of any other practitioners, specialists or hospitals/rehabilitation units/institutions that the claimant has been referred to or received treatment from. Include copies of all available specialist reports.

Name	Contact details	Date of referral

PART D : MEDICAL PRACTITIONER'S DETAILS

HPCNA Reg No: | | | | | | | | | | | | Practice No: | | | | | | | | | | |

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

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

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

Address: | |

| |

Signed at: | | this | | day of | | 20 | |

Signature of medical doctor: | |

PART E : GUIDELINES FOR THE REQUIRED CONFIDENTIAL MEDICAL REPORT

The accompanying report should consist of:

- Date of onset and chronological history of the condition
- Pre-disposing risk factors
- Detailed description of current clinical findings.
- Treatment:
  - Medication, commencement date, dose, frequency , compliance
  - Surgery/therapeutic procedures performed
  - Anticipated further surgery
  - Therapeutic procedures
  - Rehabilitation
  - Hospitalisation
  - Response to treatment
- Complications that are permanent
- Prognosis with optimal treatment
- Impact of the condition on the claimant's
  - Lifestyle,
  - Activities of daily living,
  - Work
- Attach the results of condition specific confirmatory investigations/tests

The policyholder and/or the Medical Practitioner will be notified if additional information is required.