

Accidental disability claim - confidential medical report

Treating specialist to complete this form

Dear Doctor

The medical information requested in this form is in support of a claim for accidental disability benefits provided by the member's employer. Your expertise and advice will provide a vital link in the process of assessing the claim.

As this is an extremely stressful time for the member, we would appreciate your speedy assistance with this matter.

We thank you in anticipation for your co-operation.

As this report is in support of a claim application, any cost in connection with this report will be for the account of the policyholder. Momentum will not be liable for any cost in connection with completing this report.

Please ensure that copies of all clinical / diagnostic test results and/or surgery reports etc. are attached hereto.

Completed form together with supporting documents to be faxed to 021 917 3711 or emailed to wcc@momentum.co.za or posted to PO Box 2212, Bellville 7535, attention Momentum Group Insurance disability claims.

1. Scheme details

Scheme name
Employer name

2. Member details

Title Initials
First name/s
Surname
Date of birth - -
RSA ID Yes No ID/Passport No.
Passport country of origin
Gender Male Female

3. Medical practitioner's details

Name of doctor
Qualifications/speciality
Hospital / Practice name
Practice number
Address
 Postal code
Telephone Fax
Email

4. Consultation history

Date of your first consultation with the member with regard to the current accident / condition

D	D	-	M	M	-	Y	Y	Y	Y
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Date of your last consultation with the member with regard to the current accident / condition

D	D	-	M	M	-	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---

5. Medical references

Please give the details of any other practitioners, specialists or hospitals that the member has been referred to.

Name of practitioner / hospital			
Speciality			
Postal address			
Tel no.			
Complaints referred for			
Date referred			

6. Details of injury

Date of accident

D	D	-	M	M	-	Y	Y	Y	Y
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Please describe the injuries sustained at the time of the accident.

Kindly advise the relevant ICD10 code/s.

Please tick which of the following the member has suffered the loss of (either by physical separation or due to permanent and total loss of use) and the date of such loss.

	Date
Hands	
<input type="checkbox"/> Both hands	
<input type="checkbox"/> One hand	
<input type="checkbox"/> Four fingers and the thumb of one hand	
<input type="checkbox"/> Four fingers of one hand	
Thumb	
<input type="checkbox"/> Both phalanges of a thumb	
<input type="checkbox"/> One phalanx of a thumb	
Index finger	
<input type="checkbox"/> Three phalanges	
<input type="checkbox"/> Two phalanges	
<input type="checkbox"/> One phalanx	
Middle finger	
<input type="checkbox"/> Three phalanges	
<input type="checkbox"/> Two phalanges	
<input type="checkbox"/> One phalanx	
Ring finger	
<input type="checkbox"/> Three phalanges	
<input type="checkbox"/> Two phalanges	
<input type="checkbox"/> One phalanx	
Little finger	
<input type="checkbox"/> Three phalanges	
<input type="checkbox"/> Two phalanges	
<input type="checkbox"/> One phalanx	
Feet	
<input type="checkbox"/> Both feet	
<input type="checkbox"/> One foot	

6. Details of injury (continued)

Please tick which of the following the member has suffered the loss of (either by physical separation or due to permanent and total loss of use) and the date of such loss.

	Date
Toes	
<input type="checkbox"/> All toes of one foot	
<input type="checkbox"/> Both phalanges of big toe	
<input type="checkbox"/> One phalanx of big toe	
<input type="checkbox"/> Any toe other than big toe (please specify number of toes lost)	
Sight	
<input type="checkbox"/> Total and permanent loss of sight in both eyes	
<input type="checkbox"/> Total and permanent loss of sight in one eye	
Hearing	
<input type="checkbox"/> Total and permanent loss of hearing in both ears	
<input type="checkbox"/> Total and permanent loss of hearing in one ear	
Other: please specify	

Quantify fully the specific changes in function caused by the member's impairment. Please provide clinical details indicating severity and permanence.

7. Details of permanent loss at maximal medical improvement

Date of examination

D	D	-	M	M	-	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---

Please describe the permanent loss as at maximal medical improvement. If maximal medical improvement has not yet been reached, please tick when maximal medical improvement is expected.

8. Treatment

Please provide details of all relevant medical treatment to date.

Please provide details of all planned future treatment (e.g. surgery, medication, rehabilitation, provision of prosthesis etc.).

9. Supporting documents required

I have enclosed copies of all clinical investigation reports

Yes

No

I have enclosed copies of correspondence from other practitioners, specialists or hospitals

Yes

No

I have enclosed copies of all surgery reports

Yes

No

10. Declaration

I hereby declare that I have personally examined and attended to the member and that the contents of this report are true and correct.

Medical practitioner's signature

D	D	-	M	M	-	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---

Date

Options to sign the form:

1. Print out the form, sign and scan it and send it back via email to wcc@momentum.co.za, fax it to Fax +27 (0)21 917 3711 or posted to PO Box 2212, Bellville 7535, attention Momentum Group Insurance disability claims.
2. Place your scanned signature in the signature block by following the steps outlined below.
 - Store your scanned signature as a PDF document in a safe place on your computer.
 - Select the 'comments' tab from your menu in Adobe.
 - Select the 'add stamp' icon.
 - Select custom stamps.
 - Create custom stamps.
 - You can now browse and upload your signature to save it as a custom stamp under 'sign here' in Adobe.
 - You can now go back to your 'stamps' icon and select 'sign here' and select your saved signature.
 - Place it in the document and save the document..

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