

FAMILY RESPONSIBILITY RIDER BENEFIT – ADMISSION CLAIM (DECLARATION BY DOCTOR)

The Professional Provident Society Holdings Trust No. IT 312/2011(PPS Holdings Trust) is a Registered South African Trust. PPS Insurance Company (Namibia) Limited Reg. No. 2003/122. PPS Insurance Company Limited Reg. No. 2001/017730/06. PPS Insurance Company Ltd is an Administrator of PPS Insurance Company (Namibia) Ltd.



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 client's claim.

PPS Insurance (Namibia) obtained prior written consent from the life insured in terms whereof additional information pertaining to the claim may be provided. PPS Insurance (Namibia) will always do its utmost to prevent any unauthorised disclosure of your patient's personal information. PPS Insurance (Namibia) will adhere to any laws governing the protection of (and access to) personal information; and will not use the information for any purpose not provided for in the PPS Policy Contract.

Please fax the fully completed form to PPS Insurance (Namibia) Claims +264 (0)61 411 330 or email to namibiaclaims@pps.co.za

PART A: MEMBER DETAILS

Member number:

Initials: Surname:

Date of birth: / /

Email:

Cellular:

PART B: DETAILS OF THE CLAIM

Particulars of the patient

Name:

Surname:

National ID number/Passport if no ID:

PART C: MEDICAL CONDITION

1. Primary diagnosis: ICD 10 code:

2. Secondary diagnosis (if applicable): ICD 10 code:

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

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

5. Does the patient have any pre-disposing risk factors e.g. raised cholesterol, hypertension, alcohol abuse, prior injuries, chronic disease/injury/illness which may have led to the development of the illness or claim event? Please provide details:

6. Treatment or investigations conducted for the above risk factors:

NOTE Please attach copies of all relevant investigations conducted.

Date	Details	Doctor

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 Attendant