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| **RE-OPENING OF FINALISED CLAIM APPLICATION (Treatment Pre-authorisation Request Form)**  |
| Please complete ALL sections below and submit online or email to medihelp@randmutual.co.za with supporting documents.Note: RMA liability can only be assessed on submission of a motivation for treatment, supported by a fully detailed medical report and any other results from medical investigations conducted. |
| **Treatment Request****(Please indicate type of request with an “X”)** |
| **Pre-authorisation** |  | **Re-opening of Finalised Claim** |  |
| **DETAILS OF INJURED EMPLOYEE** |
| Surname: |  | Initials: |  |
| Date of birth: |  |  |  | Gender: | M |  | F |  | Occupation:  |  |
| RMA Claim No: |  | Industry No: |  | Date of Accident: |  |  |  |
| Are you presently employed? | Yes: |  | No: |  | Pension no. |  |
| Employer: |
| Tel (H): |  | Tel (W): |  | Cell: |  |
| **DETAILS OF INJURY** |
| **Current complaints (Subjective):** |
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| **Latest investigations’ findings (enclose copies of investigations done):** |
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| **Causal relation between current complaint and original injury:** |
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| **DETAILS OF THE REQUESTED SERVICE** |
| **Name of Hospital/Facility/ Healthcare Provider:** |  |
| **Practice Number:** |  | **Date of Service/Procedure**: |  |
| **Date of Admission:** |  | **Diagnosis:** |  |
| **ICD-10 Code(s):** |  |
| **Anticipated Length of Stay (LOS):** |   | (days) | **Level of Care (LOC):** |  |
| **Claim Re-opening Motivation:** |
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| **Anticipated/Proposed Surgical Procedure and/or Treatment, with Procedure/Treatment Codes:** |  |  |
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| **Other Comments:** |  |
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I certify that I have by examination, satisfied myself that the condition of the employee is the result of the occupational disease as described above.

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| **DOCTOR/SPECIALIST/SERVICE PROVIDER DETAILS** |
| **Referring Healthcare Provider name printed:** |
| Email address: |  |
| Tel no. |  | Fax no. |  |
| Practice number: | Registered address: |
|  |  |
| Date: |  |
| Signed: |  |
| Postal code: |  |
| **Treating Healthcare Provider name printed:** |
| Email address: |  |
| Tel no. |  | Fax no. |  |
| Practice number: | Registered address: |
|  |  |
| Date: |  |
| Signed: |  |
| Postal code: |  |