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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](mailto: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: |  | | |