momentum

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 Risk disability claims.

1. Scheme details

Scheme name:	
Employer name:	

2. Member details

Title		Initials	
First name/s			
Surname			
Date of birth	D D - M M - Y Y Y Y		
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

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

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	
☐ Both hands	
☐ One hand	
☐ Four fingers and the thumb of one hand	
☐ Four fingers of one hand	
Thumb	
☐ Both phalanges of a thumb	
☐ One phalanx of a thumb	
Index finger	
☐ Three phalanges	
☐ Two phalanges	
☐ One phalanx	
Middle finger	
☐ Three phalanges	
☐ Two phalanges	
☐ One phalanx	
Ring finger	
☐ Three phalanges	
☐ Two phalanges	
☐ One phalanx	
Little finger	
☐ Three phalanges	
☐ Two phalanges	
☐ One phalanx	
Feet	
☐ Both feet	
☐ 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	
☐ All toes of one foot	
☐ Both phalanges of big toe	
☐ One phalanx of big toe	
☐ Any toe other than big toe (please specify number of toes lost)	
Sight	
☐ Total and permanent loss of sight in both eyes	
☐ Total and permanent loss of sight in one eye	
Hearing	
☐ Total and permanent loss of hearing in both ears	
☐ 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 (eg 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 Risk 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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