

## PMA FORM 2021

A claim has been lodged against a health and accident policy for this member and in order to assess this claim, we need your valued opinion and completed report urgently. The information contained in this document is strictly confidential.

### POLICYHOLDER DETAILS

Please complete this form in black ink and CAPITAL letters

Policy Number:  Inception Date:

Name and Surname:

ID number / Passport:  Mr  Mrs  Miss  Dr  Other

Email Address:

### MEDICAL PRACTITIONER DECLARATION

Doctor's Name:  Contact Number:

Email Address:  Practice Number:

Date Completed:

Are you the regular medical practitioner of the patient?  YES  NO

If no, kindly complete the referring provider's details below:

Referring Medical Practitioner:  Contact Number:

### MEDICAL HISTORY

Note: Please give the patient's medical history from the first date of consultation with yourself or your practice.

Patient Name and Surname:  Date of first consultation:

Consultation Dates	Reason for consultations, Diagnosis, Treatment and Results	Duration
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
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### DIAGNOSIS QUESTIONS

Diagnosis:

Date of diagnosis:

Treatment relates to the following conditions:

On which date did the patient first become aware of the symptoms?:

List the surgical procedure/s to be undertaken and/or reason for hospitalisation:

I, the undersigned, a registered medical practitioner, certify that the following information provided is an accurate reflection of the Insured's medical history and is true, correct and complete.

Signature of medical doctor/ practitioner:  Date:

Official stamp and address of medical doctor/ practitioner:

Please return this form to: claims@sirago.co.za