



Caring | Compassionate | Compensation

PRE-AUTHORISATION REQUEST FORM

Submit online or email to medihelp@randmutual.co.za

Please indicate your request type with an X:

Pre-authorisation

Re-opening of a finalised claim

PATIENT DETAILS

Surname:

First Names:

Name of Employer:

Date of Birth:

ID Number:

RMA Claim No:

Date of Accident:

Pension No:

Cell No:

PROVIDER DETAILS

Please Note: Liability can only be assessed by RMA on submission of a motivation for treatment, supported by a fully detailed medical report and any other results from medical investigations conducted.

Name of referring doctor:

Tel:

Email:

Name of treating doctor:

Practice No:

Fax No:

Tel:

Email:

DETAILS OF REQUESTED TREATMENT

Name of Hospital/Institution:

Date of Admission:

Date of procedure/service:

ICD10 Code/Diagnosis:

Anticipated Procedure/Treatment Codes:

Signature:

Date:

Name:

TO BE COMPLETED BY OR ON BEHALF OF THE INJURED EMPLOYEE

Name:

Surname:

Tel(h):

Cell:

Address:

Code:

RMA Claim No:

Pension No:

Date of Accident:

Are you presently employed?
Yes

No

If yes, name of Employer:

In case of queries, please call our Contact Centre: 0860 222 132



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Contact Person:	Tel:
Current earnings (please submit payslips for past 6 months):	
FOR OFFICE USE ONLY	
HPAC:	TPAC:
TTD: Yes ☐ No ☐	TTD Auth No:
Anticipated period to be booked off:	
TTD based on RMA RRD and MMI ICD10 Code:	
Accident earnings:	Current earnings: