THIRD PARTY CLAIM FORM

RAF 1

21 DECLARATION AND CONSENT

The Consent granted to the Road Accident Fund (RAF) in this paragraph authorises the RAF to obtain copies of any records and to access any information which relates to this claim for compensation and to contact any person or entity for purposes of obtaining or verifying such information and /or documentation.

I, _____ (name and surname of claimant),
declare that, to the best of my knowledge, the information provided in this Third Party Claim Form is true and correct in every respect; and

I confirm that I am claiming compensation:

in my personal capacity as a result of injuries I sustained in the accident; alternatively

in my personal and / or representative capacity as _____ (state capacity) on behalf of _____ (name and surname of injured) who sustained injuries in the accident; alternatively

in my personal and / or representative capacity as _____ (state capacity) of _____ (state name of the deceased) who died as a result of the injuries sustained in the accident.

(Indicate, and if applicable complete, the applicable statement above)

I hereby consent to the release, to the Road Accident Fund, of copies of all documentation and /or information, including, but not limited to, documentation and /or information of a medical or financial nature, in the possession of any person or entity, which documentation or information, in any way, relates to this claim for compensation arising from the motor vehicle accident detailed in the claim form

I further consent to, and authorise, the Road Accident Fund to contact any person or entity for purposes of obtaining or verifying such information and /or documentation.

Signature of the Claimant	Signature of the Witness

THIRD PARTY CLAIM FORM

RAF 1

22 MEDICAL REPORT

Section 24(2)(a) provides that this report shall be completed by the medical practitioner who treated the injured or deceased person for the bodily injuries sustained by him/her in the accident from which this claim arises

1. DETAILS OF PATIENT

Name

Surname

ID Number

Date of birth

YYYY/MM/DD

2. PAST EMERGENCY MEDICAL TREATMENT

Note that, in terms of the regulations, emergency medical treatment is defined as "...the immediate, appropriate and justifiable medical evaluation, treatment and care required in an emergency situation in order to preserve the person's life or bodily functions, or both"

Did the patient receive emergency medical treatment, as defined

☐ Yes ☐ No

If you answered YES, please furnish the following information in respect of such treatment–

What was the nature of the treatment?

☐ Emergency transport

☐ Hospital care

☐ ICU

☐ Other, if other please indicate nature of the treatment

ICD 10 Code	Treatment plan

Kindly furnish the ICD 10 codes applicable to the emergency medical treatment provided to the patient and motivate why the treatment is viewed as emergency medical treatment. Should the space provided in this claim form be insufficient to answer any question attach a further page(es) to this claim form in which such further information can be provided to the RAF.

THIRD PARTY CLAIM FORM

RAF 1

MEDICAL REPORT

3. PAST NON-EMERGENCY MEDICAL TREATMENT

Note that all medical evaluations and treatment that fall outside the prescribed definition of emergency medical treatment, is non-emergency medical treatment.

Did the patient receive non-emergency medical treatment?

☐ Yes ☐ No

If you answered YES, please furnish the following information in respect of such treatment.
In the schedule below, kindly identify the specific ICD 10 code(s) applicable and describe the treatment administered

ICD 10 Code	Treatment plan

4. PRE-EXISTING MEDICAL CONDITIONS

Did the patient suffer from any pre-existing condition(s) (injury, illness, sickness, disease, or other physical, medical, mental or nervous condition, disorder or ailment).

☐ Yes ☐ No

If you answered YES, please identify the pre-existing condition(s), furnish the applicable ICD 10 code(s) (if such a code exists) and describe the impact of the injury(ies) sustained in the accident on such pre-existing condition(s)

Pre-existing condition	ICD 10 Code	Impact of accident

THIRD PARTY CLAIM FORM

RAF 1

MEDICAL REPORT

5. FUTURE MEDICAL TREATMENT

Is the patient currently receiving ongoing medical treatment for the injury(ies) sustained in the accident, or is it foreseen that the patient would require future medical treatment for such injury(ies)

☐ Yes ☐ No

If you answered YES, please furnish the name(s) and contact number(s) of the service provider(s) who will be rendering treatment, future treatment.

6. MEDICAL TREATMENT IN MEDICAL FACILITY/HOSPITAL

Was the patient admitted to a medical facility / hospital as a result of the injury(ies) sustained in the accident, or did the patient receive treatment at a medical facility / hospital for such injury(ies)

☐ Yes ☐ No

If you answered YES, please furnish the name(s) and contact number(s) of the hospital / facility, and if admitted, the date admitted and date discharged

Name of Hospital / Facility	Contact number	Date admitted	Date discharged
		YYYY/MM/DD	YYYY/MM/DD
		YYYY/MM/DD	YYYY/MM/DD
		YYYY/MM/DD	YYYY/MM/DD
		YYYY/MM/DD	YYYY/MM/DD

7. MEDICAL PRACTITIONERS DETAIL'S

Name

Surname

Qualifications

Practice Number (HPCSA and/or BHF)

Telephone number

Facsimile number

Cell number

Postal Address

Physical Address

THIRD PARTY CLAIM FORM

RAF 1

DECLARATION

DECLARATION

I hereby declare that to the best of my knowledge and belief the information set out in this medical report is true and correct in every respect.

Signature of medical practitioner

OFFICIAL STAMP

Signed At

Date

PAYMENT

SUPPLIER CLAIM FORM

RAF 2

1 SUPPLIER DETAILS

Supplier name

Practice number (BHF/HPCSA)

Tax reference Number

Physical Address

Postal Address

Telephone number

Facsimile number

Cellular number

How would you prefer us to contact you?

Email ☐ SMS ☐ Post ☐ Tel ☐

Cell ☐

2 SUPPLIER'S BANK ACCOUNT DETAILS

If your claim is sucessful the RAF will pay you directly. Please provide bank account details for payment of compensation due to you.

Bank (Name)

Branch number

Account Number

Name of Account holder

3 BANK ACCOUNT DETAILS OF THE SUPPLIER REPRESENTATIVE

If the suppliers claim is successful, the RAF will pay the compensation to the supplier directly and cost (if due) to the supplier's representative. Please provide details of the account into which you want the costs to be paid.

Account Number

Branch Code

Bank Name

Name of account holder

Kindly attach one of the following documents to the claim form to enable the RAF to verify the banking details: a cancelled cheque or a certified legible copy/original statement of account which clearly indicates the account holder's name, account- and branch number, or an original letter from the bank (on an official letterhead) which confirms the account holder's name, account- and branch number.

SUPPLIER CLAIM FORM

RAF 2

4 MOTOR VEHICLE ACCIDENT DETAILS

In order for the RAF to assess this claim please provide the following information.

Date of accident
YYYYMMDD

Time of accident
HHMM

Place of accident (street number and name, suburb, town, province)

SAPS station where the accident was reported

Accident report number

Kindly attach to this claim form a copy of the accident report or a statement by the injured describing the events leading up to the accident.

5 INJURED'S / DECEASED'S DETAILS

Title

Surname

Name

Date of birth
YYYYMMDD

ID Number:

Tax reference Number

Residential Address

Postal Address

Home telephone number

Work telephone number

Cell number

Email

(Please attach a copy of the injured's identity document or, if applicable, a copy of the deceased's death certificate and the applicable inquest record / charge sheet)

6 COMPENSATION CLAIMED

What are you claiming for?

Category of claim	Amount Claimed
☐ Emergency medical treatment (attach original invoice)	R
☐ Non-emergency medical treatment (attach original invoice)	R
Total Amount Claimed	R

SUPPLIER CLAIM FORM

RAF 2

7 PAST EMERGENCY MEDICAL TREATMENT

Note that, in terms of the regulations, emergency medical treatment is defined as "...the immediate, appropriate and justifiable medical evaluation, treatment and care required in an emergency situation in order to preserve the person's life or bodily functions, or both"

Did the patient receive emergency medical treatment, as defined,

☐ Yes ☐ No

If you answered YES, please furnish the following information in respect of such treatment–

What was the nature of the treatment?

☐ Emergency transport

☐ Hospital care

☐ ICU

☐ Other, if other please indicate nature of the treatment

ICD 10 Code	Treatment plan

Kindly furnish the ICD 10 codes applicable to the emergency medical treatment provided to the patient and motivate why the treatment is viewed as emergency medical treatment. Should the space provided in this claim form be insufficient to answer any question you are welcome to attach a further page(es) to this claim form in which such further information can be provided to the RAF.

SUPPLIER CLAIM FORM

RAF 2

8 PAST NON EMERGENCY MEDICAL TREATMENT

Note that all medical evaluations and treatment that fall outside the prescribed definition of emergency medical treatment, is non-emergency medical treatment.

Did the patient receive non-emergency medical treatment,

☐ Yes ☐ No

If you answered YES, please furnish the following information in respect of such treatment

What was the nature of the treatment?

☐ Transport

☐ Hospital care

☐ Other, if other please indicate nature of the treatment

In the schedule below, kindly identify the specific ICD 10 code(s) applicable to the evaluation(s) / treatment provided to the patient and describe the treatment administered. **(attach detailed invoice + medical investigation reports)**

ICD 10 Code	Treatment plan

9 PRE-EXISTING MEDICAL CONDITIONS

Did the patient suffer from any pre-existing condition(s) (injury, illness, sickness, disease, or other physical, medical, mental or nervous condition, disorder or ailment) that existed at the time of the accident

☐ Yes ☐ No

If yes, please provide details.

SUPPLIER CLAIM FORM

RAF 2

10 MEDICAL TREATMENT IN MEDICAL FACILITY/HOSPITAL

Name of Hospital / Facilitiy	Contact number	Date admitted	Date discharge
		YYYY/MM/DD	YYYY/MM/DD
		YYYY/MM/DD	YYYY/MM/DD
		YYYY/MM/DD	YYYY/MM/DD
		YYYY/MM/DD	YYYY/MM/DD
		YYYY/MM/DD	YYYY/MM/DD
		YYYY/MM/DD	YYYY/MM/DD
		YYYY/MM/DD	YYYY/MM/DD
		YYYY/MM/DD	YYYY/MM/DD
		YYYY/MM/DD	YYYY/MM/DD

11 DECLARATION

I hereby declare that:

1) To the best of my knowledge and belief the information set out in this form is true and correct in every respect;
2) The accommodation in a hospital or nursing home and the treatment, or goods supplied, referred to herein, were supplied to the injured person; and
3) I have not / the supplier has not received payment from any other source, in respect of the accommodation in a hospital or nursing home and the treatment, or goods supplied, referred to in this claim form, and should I / the supplier receive any payment in respect thereof from any other source I / the supplier shall disclose full details thereof to the Road Accident Fund.

Signature of supplier, supplier's duly authorised representative or agent. Where the supplier is a legal entity attach written proof of the authorisation in terms of which the signatory is authorised to sign this claim form. Where the supplier is represented by an agent attach written proof of the agent's mandate.

Signed at

Date YYYY/MM/DD

OFFICIAL STAMP

12 SUBSTANTIAL COMPLIANCE

Please complete the following information to validate your claim for substantial compliance to Section 24 of the RAF Act.

1. The identity of the injured/deceased - (paragraph 5).
2. The date and place of accident (paragraph 4)
3. A precise indication of the amounts claimed as compensation (paragraph 6);
4. Attach specified accounts, vouchers, original invoices etc. to support your claim for medical expenses;
5. Complete this form as prescribed in Section 24 of the RAF Act.
6. Should the space provided in this claim form be insufficient to answer any question you are welcome to attach a further page(es) to this claim form in which such further information can be provided to the RAF.
7. Should you require any assistance with the completion of this claim form please feel free to contact the RAF on ShareCall number 0860 2355 23

ACCIDENT REPORT FORM
(SECTIONS 22(1)(a) OF ACT NO. 56 OF 1996

RAF3

1) When any person has been injured or killed as a result of the driving of a motor vehicle, the owner and / or the driver of that motor vehicle must report that accident to the Fund on this form within 14 days, failing which the compensation paid to the third party may be recovered from that owner or driver.
2) Should the space provided in this claim form be insufficient to answer any question you are welcome to attach a further page(es) to this claim form in which such further information can be provided to the RAF.
3) Should you require any assistance with the completion of this claim form please feel free to contact the RAF on ShareCall number 0860 2355 23

Postage will be paid by the Addressee

No postage necessary if posted in the Republic of South Africa

CHIEF EXECUTIVE OFFICER
P O Box 2743
PRETORIA
0001

1 PARTICULARS OF THE DRIVER OF THE VEHICLE

Name(s)

Surname

ID Number/Passport Number

Citizenship

Telephone

Facsimile

Cell Number

E-mail address

Physical address

Postal address

Drivers License Number

Date issued

Endorsements, if any

Physical / mental defects, if any

State whether you are also the owner of the vehcile

ACCIDENT REPORT FORM
(SECTIONS 22(1)(a) OF ACT NO. 56 OF 1996

RAF3

2 PARTICULARS OF THE OWNER OF THE VEHICLE - COMPLETE WHERE THE DRIVER WAS NOT THE OWNER

Name(s)

Surname

ID Number / Passport Number

Citizenship

Telephone number

Facsimile number

Cell number

E-mail address

Physical address

Postal address

3 PARTICULARS OF THE MOTOR VEHICLE

Registration number

Body (i.e. sedan, truck, bus etc.)

Color

Make

Model

Year

4 PARTICULARS OF OTHER MOTOR VEHICLES INVOLVED IN THE ACCIDENT

Vehicle 1

Registration number

Name(s) and surname of driver

Telephone number / Cell number

Name(s) and surname of owner

Physical address

Postal address

Vehicle 2

Registration number

Name(s) and surname of driver

Telephone number / Cell number

Name(s) and surname of owner

Physical address

Postal address

ACCIDENT REPORT FORM
(SECTIONS 22(1)(a) OF ACT NO. 56 OF 1996

RAF3

4 PARTICULARS OF OTHER MOTOR VEHICLES INVOLVED IN THE ACCIDENT

Vehicle 3

Registration number

Name(s) and surname of driver

Telephone number / Cell number

Name(s) and surname of owner

Physical address

Postal address

Vehicle 4

Registration number

Name(s) and surname of driver

Telephone number / Cell number

Name(s) and surname of owner

Physical address

Postal address

5 PARTICULARS OF THE ACCIDENT

What was the date of the accident?

What was the time of the accident?

Where did the accident take place?

At which police station was the accident reported?

What is the police reference number?

6 PARTICULARS OF WITNESS(ES) TO THE ACCIDENT

Witness 1

Name(s)

Surname

ID Number / Passport Number

Telephone number

Facsimile number

Cell number

E-mail address

Physical address

Postal address

ACCIDENT REPORT FORM
(SECTIONS 22(1)(a) OF ACT NO. 56 OF 1996

RAF3

6 PARTICULARS OF WITNESS(ES) TO THE ACCIDENT

Witness 2

Name(s)

Surname

ID Number / Passport Number

Telephone number

Facsimile number

Cell number

E-mail address

Physical address

Postal address

6 PARTICULARS OF WITNESS(ES) TO THE ACCIDENT

Witness 3

Name(s)

Surname

ID Number / Passport Number

Telephone number

Facsimile number

Cell number

E-mail address

Physical address

Postal address

ACCIDENT REPORT FORM
(SECTIONS 22(1)(a) OF ACT NO. 56 OF 1996

RAF3

7 PARTICULARS OF PERSON(S) INJURED/DECEASED

Person 1

Name(s)

Surname

ID Number / Passport Number

Telephone number

Facsimile number

Cell Number

E-mail address

Physical address

Postal address

State whether the injured / deceased was a driver, passenger, cyclist or pedestrian.

7 PARTICULARS OF PERSON(S) INJURED/DECEASED

Person 2

Name(s)

Surname

ID Number / Passport Number

Telephone number

Facsimile number

Cell Number

E-mail address

Physical address

Postal address

State whether the injured / deceased was a driver, passenger, cyclist or pedestrian.

8 CONDITIONS AT THE TIME OF THE ACCIDENT

Time of day (i.e. dawn, day, dusk, night)

Weather conditions (i.e. sunny, misty, cloudy, raining, etc.)

Visibility (i.e. good, reasonable, bad, etc.)

Road surface (i.e. gravel, sand, tar, etc.)

Street lights - on or off

Own vehicle's lights – off, dim, bright

Other vehicle's lights – off, dim , bright

Speed of own vehicle at time of accident

ACCIDENT REPORT FORM
(SECTIONS 22(1)(a) OF ACT NO. 56 OF 1996

RAF3

9 SKETCH PLAN OF THE SCENE OF THE ACCIDENT

N

W E

S

10 DETAILED DESCRIPTION OF THE ACCIDENT

ACCIDENT REPORT FORM
(SECTIONS 22(1)(a) OF ACT NO. 56 OF 1996

RAF3

11 DECLARATION

I / we hereby declare that to the best of my / our knowledge and belief the information set out in this form is true and correct in every respect.

Signature of driver

Signature of owner

Signed at

Date YYYY/MM/DD

SERIOUS INJURY ASSESSMENT REPORT

RAF 4

(a) A claim for non-pecuniary loss ("general damages" or "pain and suffering") will not be considered unless this report is duly completed and submitted.
(b) The Road Accident Fund Act (Act No. 56 of 1996) requires this report to be compiled by a medical practitioner, registered in terms of the Health Professions Act (Act No. 56 of 1974).
(c) The assessment of the serious injury should be conducted in terms of the method provided in the Regulations promulgated under the Road Accident Fund Act.
(d) Submissions, medical reports and opinions may be submitted as annexures to this report.
(e) If any section of the form is not applicable, mark that section "N/A".
(f) The impairment evaluation reports for Upper Extremities, Lower Extremities and Spine and Pelvis are annexed. If the injury caused an impairment to another body part or system, attach the report specified in the AMA Guides (6th Ed).
(g) In completing this report, refer to the figures, tables and page numbers from the AMA Guides (6th Ed).

1 DETAILS OF PATIENT

Name and Surname

Date of assessment YYYY/MM/DD

ID Number

Date of accident YYYY/MM/DD

Claim number (if available)

Contact number

2 DETAILS OF MEDICAL PRACTIONER

Name & Surname

Telephone number

Practice Number (HPCSA and/or BHF)

E-mail address

3 LIST OF NON-SERIOUS INJURIES

In terms of the Road Accident Fund Act (Act No. 56 of 1996) and Regulation 3(1)(b)(i) promulgated thereunder, the Minister may publish in the Gazette, after consultation with the Minister of Health, a list of injuries which are for purposes of section 17 of the Act not to be regarded as serious injuries and no injury shall be assessed as serious if that injury meets the description of an injury which appears on the list. Once published, this part must be completed with reference to the list. A copy of the latest version of the list is available at www.raf.co.za. For more information contact the Road Accident Fund at ShareCall-number 0860 235 5523.

Number	Description of injury

SERIOUS INJURY ASSESSMENT REPORT

RAF 4

4 AMA IMPAIRMENT RATING: TO BE COMPLETED IF INJURY IS NOT ON LIST OF NON-SERIOUS INJURIES

4.1 Describe the nature of the motor vehicle accident
4.2 Medical Treatment rendered from date of accident to present
4.3 Current symptoms and complaints
4.4 Diagnosis
4.5 Conclusion regarding Physical Examination
4.6 Conclusion regarding Clinical Studies. (Review and document actual studies and findings from relevant diagnostic studies, Imaging including X-rays, CT,MRI,etc)
4.7 Medical History
4.8 Social and Personal history

SERIOUS INJURY ASSESSMENT REPORT

RAF 4

4 AMA IMPAIRMENT RATING: TO BE COMPLETED IF INJURY IS NOT ON LIST OF NON-SERIOUS INJURIES

4.9 Educational and Occupational history
4.10 Has the patient reached MMI?
4.11 Specify details regarding apportionment, if any
4.12 A clear, accurate, and complete report must be provided to support a rating of impairment with reference to clinical evaluation analysis of findings and discussion of how the impairment rating was calculated.
The following impairment evaluation reports are annexed:
·Annexure A: Upper Extremities (Chapter 15)
·Annexure B: Lower Extremities (Chapter 16)
·Annexure C: Spine and Pelvis (Chapter 17)
4.13 Exceptions

5 SERIOUS INJURY: THE NARRATIVE TEST

If the injury is not on the list of non-serious injuries and did not result in 30 per cent Whole Person Impairment, as provided in the AMA Guides, consider whether the injury resulted in any of the consequences set out below. Provide full details. If necessary, support the opinion with reports attached as annexures.

5.1 Serious long-term impairment or loss of a body function

5.2 Permanent serious disfigurement

5.3 Severe long-term mental or severe long-term behavioural disturbance or disorder

5.4 Loss of a foetus

SERIOUS INJURY ASSESSMENT REPORT

RAF 4

6 DECLARATION

I declare that to the best of my knowledge and belief the information and opinions set out in this report are true and correct in every respect.

Signature of Medical Practitioner	
	OFFICIAL STAMP
Signed at	
Date	YYYY-MM-DD

ANNEXURE A - UPPER EXTREMITY IMPAIRMENT EVALUATION

Name:		Exam Date:
ID Number:	Sex: F M Side: R L	Birth Date:
Diagnosis:		Injury Date:

	Diagnosis-Based Impairments				
Grade	Diagnosis / Criteria	Assigned Class	Grade Modifier Adjustments	Assigned Dx Grade	Final UEI
Digit (D) Wrist (W) Elbow (E) Shoulder(S)		0 1 2 3 4	Net GMFH 0 1 2 3 4 GMPE 0 1 2 3 4 GMCS 0 1 2 3 4 (Optional: QuickDASH Score:) Net Adjustment = (GMFH – CDX) + (GMPE – CDX) – (GMCS – CDX)	≤-2 -1 0 +1 ≥+2 A B C D E	
D W E S		0 1 2 3 4	Net GMFH 0 1 2 3 4 GMPE 0 1 2 3 4 GMCS 0 1 2 3 4 (Optional: QuickDASH Score:) Net Adjustment = (GMFH – CDX) + (GMPE – CDX) – (GMCS – CDX)	≤-2 -1 0 +1 ≥+2 A B C D E	
D W E S		0 1 2 3 4	Net GMFH 0 1 2 3 4 GMPE 0 1 2 3 4 GMCS 0 1 2 3 4 (Optional: QuickDASH Score:) Net Adjustment = (GMFH – CDX) + (GMPE – CDX) – (GMCS – CDX)	≤-2 -1 0 +1 ≥+2 A B C D E	
	Combined UEI				

Peripheral Nerve/ Entrapments					
Nerve	Sensory and Motor Grading	Assigned Class	Grade Modifier Adjustments	Assigned Dx Grade	Combined UEI
	Sensory Deficit: 0 1 2 3 4 n/a Motor Deficit: 0 1 2 3 4 n/a	Sensory Deficit: 0 1 2 3 4 Motor Deficit: 0 1 2 3 4 n/a	GMFH 0 1 2 3 4 n/a GMCS 0 1 2 3 4 n/a GMFH 0 1 2 3 4 n/a GMCS 0 1 2 3 4 n/a	Sensory: A B C D E Motor: A B C D E	
Entrapment					
	Electrodiagnostics:		Test: 0 1 2 3 4 n/a History 0 1 2 3 4 n/a Physical 0 1 2 3 4 n/a	Average: Functional Grade: Normal Mild Moderate Severe	

CRPS I Impairment				
Points	Assigned Class	Adjustments	Assigned Grade	Final UEI
	0 1 2 3 4	FH 0 1 2 3 4 n/a PE 0 1 2 3 4 n/a CS 0 1 2 3 4 n/a	A B C D E	

Amputation				
Level	Assigned Class	Adjustments	Assigned Grade	Final UEI
	0 1 2 3 4	FH 0 1 2 3 4 n/a PE 0 1 2 3 4 n/a CS 0 1 2 3 4 n/a	A B C D E	

Motion		
Joint	Total UEI	Assigned Class
		0 1 2 3 4
		0 1 2 3 4
		0 1 2 3 4
Combined UEI		

Signed: _____ Name (Print): _____ Date: _____

Adjustment Abbreviations
S = Shoulder
E = Elbow
W = Wrist
H = Hand
D = Digit
GMFH = Grade Modifier Functional History
GMPE = Grade Modifier Physical Examination
GMCS = Grade Modifier Clinical Studies

Summary	Final UEI
Diagnosis-Based Impairment	
Peripheral Nerve	
Entrapment	
CRPS (Stand-alone)	
Amputation	
Range of Motion (Stand-alone)	
Final Combined Impairment	
Whole Person Impairment	
Regional Impairments	

ANNEXURE B - LOWER EXTREMITY IMPAIRMENT EVALUATION

Name:	**Exam Date:**
ID Number: Sex: F M Side: R L	**Birth Date:**
Diagnosis:	**Injury Date:**

	Diagnosis-Based Impairments				
Grade	**Diagnosis / Criteria**	**Assigned Class**	**Grade Modifier Adjustments**	**Assigned Dx Grade**	**Final UEI**
Digit (D) Wrist (W) Elbow (E) Shoulder(S)		0 1 2 3 4	Net GMFH 0 1 2 3 4 GMPE 0 1 2 3 4 GMCS 0 1 2 3 4 (Optional: QuickDASH Score:) Net Adjustment = (GMFH – CDX) + (GMPE – CDX) + (GMCS – CDX)	≤–2 –1 0 +1 ≥+2 A B C D E	
D W E S		0 1 2 3 4	Net GMFH 0 1 2 3 4 GMPE 0 1 2 3 4 GMCS 0 1 2 3 4 (Optional: QuickDASH Score:) Net Adjustment = (GMFH – CDX) + (GMPE – CDX) + (GMCS – CDX)	≤–2 –1 0 +1 ≥+2 A B C D E	
D W E S		0 1 2 3 4	Net GMFH 0 1 2 3 4 GMPE 0 1 2 3 4 GMCS 0 1 2 3 4 (Optional: QuickDASH Score:) Net Adjustment = (GMFH – CDX) + (GMPE – CDX) + (GMCS – CDX)	≤–2 –1 0 +1 ≥+2 A B C D E	
	Combined UEI				

Peripheral Nerve/ Entrapments					
Nerve	**Sensory and Motor Grading**	**Assigned Class**	**Grade Modifier Adjustments**	**Assigned Dx Grade**	**Combined UEI**
	Sensory Deficit: 0 1 2 3 4 n/a Motor Deficit: 0 1 2 3 4 n/a	Sensory Deficit: 0 1 2 3 4 Motor Deficit: 0 1 2 3 4 n/a	GMFH 0 1 2 3 4 n/a GMCS 0 1 2 3 4 n/a GMFH 0 1 2 3 4 n/a GMCS 0 1 2 3 4 n/a	Sensory: A B C D E Motor: A B C D E	
Entrapment					
	Electrodiagnostics:		Test 0 1 2 3 4 n/a History 0 1 2 3 4 n/a Physical 0 1 2 3 4 n/a	Average: Functional Grade: Normal Mild Moderate Severe	

CRPS I Impairment				
Points	**Assigned Class**	**Adjustments**	**Assigned Grade**	**Final UEI**
	0 1 2 3 4	FH 0 1 2 3 4 n/a PE 0 1 2 3 4 n/a CS 0 1 2 3 4 n/a	A B C D E	

Amputation Level	**Assigned Class**	**Adjustments**	**Assigned Grade**	**Final UEI**
	0 1 2 3 4	FH 0 1 2 3 4 n/a PE 0 1 2 3 4 n/a CS 0 1 2 3 4 n/a	A B C D E	

Motion		
Joint	**Total UEI**	**Assigned Class**
		0 1 2 3 4
		0 1 2 3 4
		0 1 2 3 4
Combined UEI		

Adjustment Abbreviations
S = Shoulder
E = Elbow
W = Wrist
H = Hand
D = Digit
GMFH = Grade Modifier Functional History
GMPE = Grade Modifier Physical Examination
GMCS = Grade Modifier Clinical Studies

Summary	**Final UEI**
Diagnosis-Based Impairment	
Peripheral Nerve	
Entrapment	
CRPS (Stand-alone)	
Amputation	
Range of Motion (Stand-alone)	
Final Combined Impairment	
Whole Person Impairment	
Regional Impairments	

Signed: _____ Name (Print): _____ Date: _____

ANNEXURE C - SPINE AND PELVIS IMPAIRMENT EVALUATION

Name:				Exam Date:	
ID Number:		Sex: F M	Side: R L	Birth Date:	
Diagnosis:				Injury Date:	
	Diagnosis-Based Impairments				
Grid	Diagnosis / Criteria	Class Diagnosis (CDX)	Grade Modifier Adjustments	Net Adjustment Value and Assigned Grade Modifier	Whole Person Impairment
Cervical (C)		0 1 2 3 4	GMFH 0 1 2 3 4 n/a GMPE 0 1 2 3 4 n/a GMCS 0 1 2 3 4 n/a Net Adjustment = (GMFH – CDX) + (GMPE – CDX) + (GMCS – CDX)	Adjusted Grade = Net Adjustment applied to Default Value C ≤-2 -1 0 +1 ≥2 A B C D E	
Thoracic (T)		0 1 2 3 4	GMFH 0 1 2 3 4 n/a GMPE 0 1 2 3 4 n/a GMCS 0 1 2 3 4 n/a	Adjusted Grade ≤-2 -1 0 +1 ≥2 A B C D E	
Lumbar (L)		0 1 2 3 4	GMFH 0 1 2 3 4 n/a GMPE 0 1 2 3 4 n/a GMCS 0 1 2 3 4 n/a	Adjusted Grade ≤-2 -1 0 +1 ≥2 A B C D E	
Pelvis (P)		0 1 2 3 4	GMFH 0 1 2 3 4 n/a GMPE 0 1 2 3 4 n/a GMCS 0 1 2 3 4 n/a	Adjusted Grade ≤-2 -1 0 +1 ≥2 A B C D E	

Signed: Date: Whole Person Impairment:

NOTIFICATION OF DISPUTE

RAF5

1 TO BE COMPLETED WHERE THIRD PARTY REQUESTS DISPUTE RESOLUTION:

Title | Surname

Name

Date of birth | Sex | Male | Female

YYYY/MM/DD

ID Number / Passport Number

Residential Address

Postal Address

Home telephone number

Work telephone number

Fax number

Cell

Email

2 TO BE COMPLETED WHERE THE FUND REQUESTS DISPUTE RESOLUTION:

Complete available details of the third party:

Title | Surname

Name

Date of birth | Sex | Male | Female

YYYY/MM/DD

ID Number / Passport number

Residential Address

Postal Address

Home telephone number

Work telephone number

Fax number

Cell phone number

Email

NOTIFICATION OF DISPUTE

RAF5

2 TO BE COMPLETED WHERE THE FUND REQUESTS DISPUTE RESOLUTION:

Details of Fund contact person:

Title

Surname

Name

Postal Address

Telephone number

Fax number

Email

Reference

3 INDICATE NATURE OF DISPUTE RESOLUTION:

☐ Dispute of assessment - complete paragraphs 4 and 6.

☐ Dispute of rejection of serious injury assessment report - complete paragraphs 5 and 6.

4 ASSESSMENT DETAILS:

Who performed the assessment?

When was the assessment performed?

YYYY/MM/DD

When were you advised of the outcome of the assessment?

YYYY/MM/DD

(Please attach the serious injury assessment report - RAF4)

5 REJECTION DETAILS:

When was the serious injury assessment report rejected?

YYYY/MM/DD

When were you advised that the report has been rejected?

YYYY/MM/DD

(Please attach reasons furnished by the Fund)

NOTIFICATION OF DISPUTE

RAF5

6 DETAILS OF DISPUTE

Set out the grounds upon which you are disputing the assessment / rejection of the serious injury assessment report. Attach all submissions, medical reports and opinions that you rely upon.

Signature of the person requesting dispute resolution

Date

PLEASE SEND THIS NOTICE TO THE REGISTRAR OF THE HPCSA,
P O Box 205 Pretoria 0001 OR facsimile 012 328 5120 OR hpcsa@hpcsa.co.za.
(IMPORTANT: Kindly RETAIN PROOF OF WHEN this notice was posted per registered post, faxed or sent per e-mail)

NOTIFICATION OF DISPUTE

RAF5

NOTIFICATION OF DISPUTE IN RELATION TO THE ASSESSMENT OF A SERIOUS INJURY

HOW DISPUTE RESOLUTION WILL HELP YOU?

In terms of the Act and the Regulations your claim for non-pecuniary loss must be supported by a serious injury assessment report, indicating that the injury has been assessed as serious by a medical practitioner and the Fund must be satisfied that the injury has been correctly assessed as serious.

What disputes are covered by the dispute resolution service?

Dispute resolution helps you if:

- the medical practitioner has assessed your injury as "not serious"; or
- if the Fund has rejected a serious injury assessment report by a medical practitioner in terms of which your injury has been assessed as "serious".

You must indicate on the form whether you wish to dispute the assessment of the medical practitioner or the rejection of the report by the Fund. If you disagree with either of these, you may lodge a dispute with the Registrar of the Heath Professions Council of South Africa ("the HPCSA").

When must a dispute be lodged?

Within 90 days of being notified of the outcome of the assessment or being notified of the rejection of the serious injury assessment report and the reasons therefore, failing which you may apply to the Registrar of the HPCSA for approval (condonation) for late notification.

How does the dispute resolution process work?

a) Your notification must be lodged with the Registrar together with all the submissions (argument), medical reports or opinions (expert advice) that you want to rely on.

b) After you lodge your dispute, the Registrar must then inform the Fund of the dispute and give the Fund copies of all the documentation submitted by you.

c) The Fund then has 60 days to answer your case by giving the Registrar their submissions, medical reports or opinions.

d) After this, the Registrar will then inform you about the names of the medical practioners appointed to decide your dispute. You may object to these appointments if you wish to do so.

e) If asked to do so, the appeal tribunal may say that legal arguments should be made on certain issues and an attorney or advocate will then be appointed to hear such argument.

f) The appeal tribunal is given extensive powers under the regulations to enable them to deal with the dispute:

- The tribunal may tell you that you have to undergo another assessment by a medical practitioner for which the Fund will pay.
- The tribunal may say that you must appear before them so that they can examine your injury for themselves.
- The tribunal may ask you for further submissions or medical records.

g) If asked to do one of the above, you should comply with the request, otherwise the appeal tribunal may refuse to decide your dispute.

h) Ultimately, the appeal tribunal will decide your dispute and you will be informed of the outcome by the Registrar. The Fund will be obliged to accept the findings of the appeal tribunal.

How long will it take?

The appeal tribunal, appointed by the Registrar of the HPCSA to consider your dispute, must publish its findings within 90 days from the date that the dispute is referred to it, which will normally be done after the Fund has answered your case.

For further information please phone the Road Accident Fund on ShareCall-number: 0860 235 5523