SUPPLIER CLAIM FORM

Road Accident Fund

RAF 2

1 SUPPLIER DETAILS:

Supplier name

Telephone number

Practice number (BHF/HPCSA)

Facsimile number

Tax reference number

Cellular number

Physical address

How would you like us to contact you?

E-mail ☐ SMS ☐ Post ☐ Tel ☐

Cell ☐

E-mail address

Postal address

2 SUPPLIER'S BANK ACCOUNT DETAILS:

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

Bank name

Account number

Branch number

Name of account holder

3 BANK ACCOUNT DETAILS OF SUPPLIER REPRESENTATIVE:

If the supplier's 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

Bank name

Branch code

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.

4 MOTOR VEHICLE ACCIDENT DETAILS:

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

Date of accident

YYYY/MM/DD

Time of accident

HH/MM

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

YYYY/MM/DD

ID number

Tax reference number

Residential address

Postal address

Home telephone number

Work telephone number

Cell number

E-mail

(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**	

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.

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 and 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.

10 MEDICAL TREATMENT IN MEDICAL FACILITY/HOSPITAL:

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
		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 with 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 23 55 23.