SAVE AS PRINT

MAS Form 1A

State Insurance Regulatory Authority

Application for assessment of a treatment dispute

Under section 60(1), section 58(1)(a) and/or section 58(1)(b) of the *Motor Accidents Compensation Act 1999*

This form is approved by the Authority in accordance with clause 8.1 of the Medical Assessment Guidelines.

Use this form only if:

- There is a dispute between the claimant and the insurer about *whether the treatment provided or to be provided to the injured person was or is reasonable and necessary in the circumstances (s 58 (1)(a));* and/or
- There is a dispute between the claimant and the insurer about *whether any such treatment relates to the injury caused by the motor accident (s 58 (1)(b)).*

Past treatment refers to treatment which has already been provided to the claimant.

Proposed future treatment refers to treatment which has been formally recommended or proposed by the claimant's treating practitioner, but which the claimant has not yet been provided with. The intention must be that the treatment is to be provided in the future.

Definition of treatment:

In accordance with s 42 of the *Motor Accidents Compensation Act 1999* treatment means:

(a) medical treatment, or
(b) dental treatment, or
(c) the provision of rehabilitation services, or
(d) the provision of attendant care services, or
(e) the provision, replacement or repair of artificial members, eyes or teeth, crutches or other aids or spectacle glasses, whether or not at a hospital.

A treatment dispute requires that:

- The claimant has approached the insurer and requested the treatment; and that
- the insurer has had a reasonable opportunity to respond to the request.

If the insurer has responded to your request, a copy of the letter declining payment **must** be provided.

Do not use this form if:

- This dispute has been assessed by the Medical Assessment Service (MAS) before – **use a MAS Form 4AT**.
- You have a dispute about whether a payment is required to be made for treatment provided to the claimant – **use CARS Form 5A**.
- You have a dispute about the quantum (amount) to settle a claim – **use CARS Form 2A**.
- The treatment dispute is between the claimant's Workers Compensation insurer and the CTP insurer – **this can not be assessed by MAS or CARS**.

Instructions on completing the application form:

1. The applicant must complete the application form and send it to:
   a. the respondent, together with a copy of all material in support of the application that has not previously been supplied to the respondent; and
   b. MAS, with 2 copies of the application and all material in support of the application. Claimants without legal representation only need to lodge one copy of the application form and the supporting document.

How to lodge the application:

In person/Mail:

SIRA Dispute Resolution Services
Medical Assessment Service
State Insurance Regulatory Authority
Level 19, 1 Oxford Street,
Darlinghurst NSW 2010

Document Exchange:

SIRA Dispute Resolution Services
Medical Assessment Service
State Insurance Regulatory Authority
DX 10 Sydney

For assistance please contact:

DRS on 1800 34 77 88
Email DRSEnquiries@sira.nsw.gov.au
Visit www.sira.nsw.gov.au

If you need an interpreter to help you read this form, please contact:

إذا احتجت إلى مترجم لمساعدتك في قراءة هذه الإستمارة، يرجى الاتصال بـ:

如果您需要口译员帮助您阅读此表格, 请联系:

如果您需要口譯員幫助您閱讀此表格, 請聯絡:

이 양식을 읽는데 도움이 되는 통역사가 필요하시면 아래로 연락하십시오:

Nếu quý vị cần một thông dịch viên để giúp quý vị đọc mẫu đơn này, xin vui lòng liên lạc:

اگر به مترجم نیاز دارید که در خواندن این فرم کمکتان کند، لطفاً با ما تماس بگیرید:

Associated Translators & Linguists

Level 5, 72 Pitt Street, Sydney NSW 2000
Office hours: 8.30 am to 5.00 pm, Monday to Friday

Telephone: (02) 9231 3288 **Fax:** (02) 9221 4763
Email: atl@atl.com.au **Website:** www.atl.com.au

Section 1: Application

This application is made by the:

☐ Claimant ☐ Claimant's legal representative ☐ Other/Non-CTP ☐ Insurer
☐ Insurer's legal representative

Section 2: Details about the accident

Date of accident (DD/MM/YYYY)

Location of accident

If you are the claimant, the date the completed claim form sent to the insurer (DD/MM/YYYY)

If you are the insurer, the date the completed claim form received by the insurer (DD/MM/YYYY)

Section 3: Claimant information (details of the person who made this claim)

Title

Surname/family name

Given name

If known by another name

Date of birth (DD/MM/YYYY)

Gender

☐ M ☐ F ☐ Other

Claimant contact details

Street address (include unit/street/property/Lot number if applicable – must not be a PO Box)

Suburb

State

Postcode

Country (if outside Australia)

Postal address (if different to Street address)

Suburb | State | Postcode

Country (if outside Australia)

Preferred daytime contact number | Mobile number

Email

Claimant personal information

Interpreter required?

☐ Yes ☐ No

If yes, what language

Do you have a disability we should know about to help you during the application process?

Specify the disability

Claimant unavailable dates

Contact authority (claimant to complete)

The claimant hereby gives permission for MAS and the CTP Assist to contact the below named person who has been designated as an authorised contact person for this matter to discuss my claim if necessary.

Authorised contact name

Authorised contact number | Relationship to claimant (eg family, friend, lawyer)

Email

Claimant's legal representative details

Does this claimant have a legal representative? (If yes, provide details below).

☐ Yes ☐ No

Claimant's legal representative contact details

Firm

Postal address or DX address (NSW DX only)

Suburb | State | Postcode

Claimant's legal representative name

Reference | Business phone number

Email

Section 4: Insurer information

Including NSW CTP insurers, interstate insurers, the Nominal Defendant, other corporations or individuals against whom a claim is made (select only one).

☐ Is the person/entity against whom the claim is made a NSW CTP insurer?

OR

☐ Is the person/entity against whom the claim is made a non-NSW CTP insurer?

OR

☐ Is the person/entity against whom the claim is made a corporation or an individual?

Details of CTP insurer (or non-NSW CTP insurer)

Name of insurer | Insurer claim number

Postal address or DX address (NSW DX only)

Suburb | State | Postcode

Is the insurer acting for the Nominal Defendant? ☐ Yes ☐ No

Details of claims officer

Title | Claims officer name

Business phone number

Email

Insurer's legal representative details

Does this insurer have a legal representative? (If yes, provide details below).

☐ Yes ☐ No

Insurer's legal representative contact details

Firm

Postal address or DX address (NSW DX only)

Suburb | State | Postcode

Insurer's legal representative name

Reference | Business phone number

Email

Details of corporation/individual (complete this section if the claim is not made against a CTP insurer. For example, a transport company, warehouse or employer.)

Name

Postal address or DX address (NSW DX only)

Suburb | State | Postcode

Country (if outside Australia)

Business phone number

Email

Corporation/individual's legal representative details

Does this corporation/individual have a legal representative? (If yes, provide details below).

☐ Yes ☐ No

Corporation/individual's legal representative contact details

Firm

Postal address or DX address (NSW DX only)

Suburb

State

Postcode

Corporation/individual's legal representative name

Reference

Business phone number

Email

Section 5: Dispute about past treatment

Do you have more than one dispute?

☐ Yes. **You must complete a separate section 5 for each additional PAST treatment dispute.** If you have more than one PAST treatment dispute, copy this page and complete a separate section 5 for each additional PAST treatment dispute. ☐ No

Type of treatment in dispute *(eg 'physiotherapy', 'surgery' or 'medication'.)*	**List all details for this dispute** *(For treatment types eg 'attendant care services', 'dental treatment', 'domestic assistance', 'gratuitous care, 'herbal remedies', 'home modifications', 'medication-over the counter', 'medication-prescription', radiological scans', surgery-L5/S1 fusion', or 'other'.)*	**Are supporting documents attached?**	**Supporting document numbers as per list of documents attached at section 7**
		☐ Yes ☐ No	

Which injury was this treatment for? (eg 'back', 'care needs arising from all injuries' or 'psychological')

Who provided this treatment? (eg 'Dr. John Smith, GP Practice Oxford Street')

What period of treatment has the insurer refused to pay for? (eg 'from 11/01/2005 to 01/03/2005')

(DD/MM/YYYY) to (DD/MM/YYYY)

Number of sessions/hours of treatment completed? (eg 'two sessions per week' or '6 hours per day')

What is the date of the referral/recommendation for the treatment in dispute?

When was the insurer requested to approve this treatment?

Has the insurer responded to the request within 20 working days? If you have not contacted the insurer, you should do so immediately.

☐ Yes ☐ No If this application is lodged because the insurer has not responded, MAS will assess both whether the treatment is causally related and if reasonable and necessary.

If yes, what is the date of the letter from the insurer denying payment for the treatment in dispute or denying liability for the claim?

What reason has the insurer given for not paying for the treatment?

☐ Not related to injuries caused by the accident ☐ Not reasonable and necessary

Section 6: Dispute about proposed future treatment

Do you have more than one dispute?

☐ Yes. **You must complete a separate section 6 for each additional PROPOSED FUTURE treatment dispute.** If you have more than one PROPOSED FUTURE treatment dispute, copy this page and complete a separate section 6 for each additional PROPOSED FUTURE treatment dispute.

☐ No

Type of treatment in dispute *(eg 'physiotherapy', 'surgery' or 'medication'.)*	**List all details for this dispute** *(For treatment types eg 'attendant care services', 'dental treatment', 'domestic assistance', 'gratuitous care, 'herbal remedies', 'home modifications', 'medication-over the counter', 'medication-prescription', radiological scans', surgery-L5/S1 fusion', or 'other'.)*	**Are supporting documents attached?**	**Supporting document numbers as per list of documents attached at section 7**
		☐ Yes ☐ No	

Which injury is this treatment for? (eg 'back', 'care needs arising from all injuries' or 'psychological')

Who referred/recommended this treatment? (eg 'Dr. John Smith, GP Practice Oxford Street')

What period of treatment has the insurer refused to pay for? (eg 'from 11/01/2005 to 01/03/2005')

(DD/MM/YYYY) to (DD/MM/YYYY)

Number of sessions/hours recommended? (eg 'two sessions per week' or '6 hours per day')

What is the date of the referral/recommendation for the treatment in dispute?

When was the insurer requested to approve this treatment?

Has the insurer responded to the request within 20 working days? If you have not contacted the insurer, you should do so immediately.

☐ Yes ☐ No If this application is lodged because the insurer has not responded, MAS will assess both whether the treatment is causally related and if reasonable and necessary.

If yes, what is the date of the letter from the insurer denying payment for the treatment in dispute or denying liability for the claim?

What reason has the insurer given for not paying for the treatment?

☐ Not related to injuries caused by the accident ☐ Not reasonable and necessary

Section 7: Document information (documents that must be attached in support of the application (do not attach originals))

The application may be rejected or dismissed if the following are not listed below and attached to the application (do not attach originals):

- A copy of the claim form including the medical certificate.
- Referrals or recommendations for each treatment in dispute (past or proposed).
- Evidence from the treatment provider to verify the number of treatment sessions in dispute (eg invoices or list of specific dates for past only).

If available the following documents **must** be attached:

- Rejection letters from the insurer, declining payment for each treatment/service in dispute (past or proposed).

Documents MUST be provided to the other party.
You must number the first page of the top right hand corner of each document in accordance with the list below.

No additional documents will be accepted unless compliant with clause 12.10 of the Medical Assessment Guidelines.

Document number	Name of document *(eg report Dr J Smith)*	Date *(eg 29/07/2018)*
A1		
A2		
A3		
A4		
A5		
A6		
A7		
A8		
A9		
A10		
A11		
A12		
A13		
A14		
A15		
A16		
A17		
A18		
A19		
A20		

You must send 2 copies of this application and all supporting documentation to MAS. UNLESS you are a claimant without legal representation.
You must send to the respondent a copy of this application and all supporting documentation that has not previously been supplied to the respondent.
If the matter is referred for assessment, a copy of all documentation provided by the parties will be provided to the assessor/s.

If you need more space, you should use the 'extra documents information' page, continue the numbering from this page and attach it to your application.

Important facts about privacy

In handling personal and health information, the Authority is subject to the NSW *Privacy and Personal Information Protection Act 1998* and the NSW *Health Records and Information Privacy Act 2002*. The information we ask you to provide is required to enable the Authority to carry out its functions under the *Motor Accidents Compensation Act 1999*, in accordance with the Medical Assessment Guidelines.

If relevant information is not provided, the Authority may be unable to process your application.

The information collected by the Authority is for the purpose of dealing with your application. It will be used for this purpose and for any subsequent consideration of matters relevant to the claim. It may also be used for associated administrative purposes including the monitoring and review of the Motor Accidents Scheme.

Authority staff involved in these functions, any assessor(s) assigned to consider your application and their support staff will have access to the information.

You have rights to access personal and health information about you held by the Authority and to correct this information in certain circumstances. Further details about how to exercise these rights is available from the SIRA Privacy Officer on 1300 656 919.

The information will be held and stored by the State Insurance Regulatory Authority, Level 19, 1 Oxford Street, Darlinghurst NSW 2010.

Section 8: Signature section

The signature of person completing this form:

☐ Claimant ☐ Claimant's legal representative ☐ Insurer ☐ Insurer's legal representative ☐ Other

If other, relationship to claimant

Surname/family name

Given name

Signature

Date application form completed (DD/MM/YYYY)

Reason why claimant did not sign (if not legally represented)

Date application form sent to the respondent (DD/MM/YYYY)

Catalogue No. SIRA08843
Dispute Resolution Services, State Insurance Regulatory Authority
Level 19, 1 Oxford Street, Darlinghurst, NSW 2010 | The Concierge 1800 347 788
Website www.sira.nsw.gov.au

NSW GOVERNMENT | State Insurance Regulatory Authority