SAVE AS PRINT

MAS Form 6R

NSW GOVERNMENT | State Insurance Regulatory Authority

Reply to an application for a referral to MAS by a claims assessor or court

Under sections 60(1), 61(5) or section 62(1) of the *Motor Accidents Compensation Act 1999*

This form is approved by the Authority in accordance with clause 15.5 of the Medical Assessment Guidelines.

Use this form only if:

- You have received an acknowledgment from the Medical Assessment Service (MAS) of an application for referral to the MAS by a CARS assessor or court.

Instructions on completing the reply form:

1. You must within 10 working days of the date the acknowledgement letter was sent by MAS, complete the reply form and:
   a. send it to the other party, together with a single sided copy of all material in support of the reply that has not previously been supplied to the applicant; and
   b. lodge it with MAS, with a total of two single sided copies of the referral form and all material in support of the referral. Claimants without legal representation only need to lodge a single copy of the reply form and the supporting documents at MAS.
2. In accordance with cl. 12.10 of the Medical Assessment Guidelines:
   No additional documents or information sought to be added to the list of documents to be referred to the assessor may be lodged by either party after the lodgement of their application or their reply, except:
   12.10.1 by consent of the other party;
   12.10.2 in response to a specific request or direction from the Proper Officer, an assessor or an officer of MAS, in circumstances where the Proper Officer is satisfied that any such document would be of assistance to the conduct of the assessment; or
   12.20.3 if the Proper Officer is satisfied that exceptional circumstances exist; and any such documents must have been provided to the other party.

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: Reply

This reply is made by the:

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

☐ Insurer's legal representative

Claimant name

Matter number

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)

Is the information the applicant gave in section 3 correct? ☐ Yes (go to section 4) ☐ No (provide correct details)

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

Is the information the applicant gave in section 4 correct? ☐ Yes (go to section 5) ☐ No (provide correct details)

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

COMPLETE THE RELEVANT SECTION/S ONLY AT 5, 6 AND/OR 7

Section 5: Permanent impairment information

Is the information the applicant gave in section 5 correct? ☐ Yes (go to section 6) ☐ No (provide correct details)

List the injuries caused by the accident that you consider currently give rise to an assessable degree of permanent impairment in accordance with the SIRA's Permanent Impairment Guidelines and the American Medical Association's Guides to the Evaluation of Permanent Impairment Fourth Edition.

DO NOT include:

- injuries that cannot give rise to a permanent impairment under the above Guides (eg 'resolved bruising');
- symptoms or disabilities (eg 'pain', 'inability to lift heavy objects').

These injuries will not be referred for assessment.

Bodily location of injury *(eg left ankle)*	**Injury type** *(eg fracture)*	**What aspects of this injury are in dispute?** *More than one aspect can be listed, eg;* • *'degree of impairment'* • *'causation'* • *'exacerbation'* • *'apportionment'* • *'subsequent intervening event'*	**Are supporting documents attached?**	**Supporting document number as per list of documents attached (at section 8)**
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

If you need more space, copy this page and attach it to your reply.

Section 6: Dispute about past treatment

Is the information the applicant gave in section 6 correct?

☐ Yes (go to section 7 unless you wish to add additional information at the end of this form)

☐ No (provide correct details)

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 8**
		☐ 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?

☐ Yes

☐ No If you have not contacted the insurer, you should do so immediately. 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: Dispute about proposed future treatment

Is the information the applicant gave in section 7 correct?

☐ Yes (go to section 8 unless you wish to add additional information at the end of this form)

☐ No (provide correct details)

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 8**
		☐ 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 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?1

☐ Yes

☐ No If you have not contacted the insurer, you should do so immediately. 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 8: Document information (documents that must be attached in support of the reply (do not attach originals))

Do not provide copies of documents provided in the application.

If available and not included in the application, the following documents **must** be attached for permanent impairment disputes:

- A copy of the claim form including the medical certificate.
- For dental injuries attach dental records.
- For scarring attach medical evidence and/or photographs (photographs should be current and in colour).
- For brain injuries attach the ambulance report, hospital notes, neurologist's reports and/or radiological scans.

If available and not included in the application, the following documents **must** be attached for treatment disputes:

- 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).

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.

Document number	Name of document *(eg report Dr J Smith)*	Date *(eg 29/07/2018)*
R1		
R2		
R3		
R4		
R5		
R6		
R7		
R8		
R9		
R10		
R11		
R12		
R13		
R14		
R15		
R16		
R17		

You must send 2 copies of this reply and all material in support to MAS.
You must send to the applicant a copy of this reply and all material in support that has not previously been supplied to the applicant.
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 reply.

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 9: 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 reply form completed (DD/MM/YYYY)

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

Date reply form sent to the applicant (DD/MM/YYYY)

Date reply form sent to MAS (DD/MM/YYYY)

Catalogue No. SIRA08844
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

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