

Reply to an 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:

- You have received a completed application for assessment of a treatment dispute.

Instructions on completing the reply form:

- You must lodge the reply form within 20 working days of the date the Medical Assessment Service (MAS) sent the acknowledgement of the MAS 1A application. Send it to:
 - the applicant, together with a copy of all material in support of the reply that has not previously been supplied to the applicant; and
 - MAS with 2 copies of the reply and all material in support of the reply. Claimants without legal representation only need to lodge one copy of the reply form and the supporting documents.

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 application 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? If yes, what language

Yes No

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

Section 5: Dispute about past treatment

Is the information the applicant gave in section 5 correct?

Yes (go to section 6 unless you wish to add additional information at the end of this page)

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 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')

to

(DD/MM/YYYY)

(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 you have not contacted the insurer, so you should do so immediately. If the application is lodged because the insurer has not responded, MAS will assess both whether the treatment is casually 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

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 page)

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 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')

to

(DD/MM/YYYY)

(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 reply (do not attach originals))

Please refer to cl. 12.10 of the Medical Assessment Guidelines for lodgement of late additional documents or information.

i Do not provide copies of documents provided in the application.
If available and not included in the application, the following documents **must** be attached:

- Referrals or recommendations for each treatment in dispute (past or proposed)
- Rejection letters from the insurer, declining payment for each treatment/service in dispute (past or proposed)
- Evidence from the treatment provider to verify the number of treatment sessions in dispute (for example invoices, list of specific dates/past only)

i 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		
R18		
R19		
R20		
R21		
R22		

i You must send to MAS 2 copies of this reply and all material in support.
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 8: Signature section

The signature of person completing this form:

Claimant	Claimant's legal representative	Insurer	Insurer's legal representative	Other
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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)