SAVE AS PRINT

MAS Form 5A

NSW GOVERNMENT | State Insurance Regulatory Authority

Application for a review of a medical assessment

Under section 63(1) of the *Motor Accidents Compensation Act 1999*

This form is approved by the Authority in accordance with clause 16.6 of the Medical Assessment Guidelines.

Use this form only if:

- There has been an assessment by the Medical Assessment Service (MAS) and you are of the view that the original medical assessment is incorrect in a material respect.

Instructions on completing the application form:

1. An Application for Review of an Assessment must be received by MAS:
   a. within 30 working days after the date on which the certificate was sent by MAS
   b. in the case of a permanent impairment dispute assessed by more than one medical assessor with a combined certificate required, not before the combined certificate is issued, and within 30 working days after the date on which the certificate was sent by MAS.
2. 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 documents.

An application for review may not be lodged more than 30 working days after the date the MAS certificate was sent, except as provided by clause 16.5 of the Medical Assessment Guidelines.

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:

☐ 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 over the page).

☐ 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: Details about the assessment

Which assessment certificate are you seeking to have reviewed?

Assessor (name)

Date of assessment (DD/MM/YYYY)

Matter number/s

Date MAS assessment certificate sent (DD/MM/YYYY)

Date review application due (30 working days after the MAS assessment certificate was sent) (DD/MM/YYYY)

Assessment of:

☐ Permanent impairment ☐ Reasonable and necessary treatment ☐ Related treatment

Section 6: Review information

Why are you seeking a review?

In accordance with s.63(2) of the *Motor Accidents Compensation Act 1999*:

An application for the referral of a medical assessment to a review panel may only be made on the grounds that the assessment was incorrect in a material respect.

You must give detailed reasons and if you say there is more than one error explain each one in a separate paragraph. You should refer to particular sections or paragraphs that you say are incorrect.

Relevant page/paragraph of MAS certificate.

What is the error or mistake?

How is this material to the outcome of the assessment?

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

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

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		
A21		
A22		
A23		
A24		
A25		
A26		
A27		
A28		

You must send to MAS 2 copies of this application and all supporting documentation 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)

Date application form sent to MAS

(DD/MM/YYYY)

Catalogue No. SIRA08841
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