

Request for Prior Approval of Treatment

ACC32 number M12345

“Treatment providers complete this form to request and validate ongoing treatment on behalf of the patient or to request an alteration in diagnosis.”



Please indicate:

- Additional diagnosis only
- Additional diagnosis plus treatment
- Treatment only
- Change in diagnosis only
- EPN Provider
- ACC32A
- ACC32R

SECTION 1: CLAIMANT DETAILS

ACC45 number or Claim number

Claimant's name

Date of birth / / Date of injury / /

Claimant's address

Occupation Telephone

SECTION 2: TREATMENT DETAILS

Read Code(s) Treatment Profile Recommended number of treatments

Read Code(s) to be added

Number of treatments given to date Number of additional treatments requested EPN Providers indicate number of treatments at

PT02 PT04

Assessment required (only after 52 weeks): PT01 PT03 TMTI

SECTION 3: PROVIDER DETAILS

NAME OF TREATING PRACTITIONER/ADDRESS OR STAMP AND PROVIDER STAMP

Provider type

ACC Provider number

Telephone

SECTION 4: HISTORY, EXAMINATION AND DIAGNOSIS

Initial diagnosis

How did the injury occur?

Current diagnosis (include a precise description of the current condition and where appropriate the reason for a change of Read Code)

Explain how the current condition has been caused by the covered injury

Why has the condition not resolved within the treatment profile trigger number/treatment limit or within the expected timeframe? (Include pre-existing factors.)

SECTION 5: CURRENT STATUS, MANAGEMENT AND PROGNOSIS

List measurable goals achieved as a result of treatment to date (if the patient has been treated at your clinic)

A) Signs and Symptoms	B) Function

List current measurable limitations (from this injury)

A) Signs and Symptoms	B) Function

Goals (current, specific and measurable)	Treatment plan (include self-management)	Expected Timeframe (include treatment frequency)
A) Signs and Symptoms		
B) Functional		

Please attach relevant medical information (e.g. x-ray reports, medical notes)

Recommendation for further management if current treatment goals not met?

SECTION 6: PATIENT DECLARATION

I declare

- That the information (including personal details) on this form is true and correct
- I accept that I have to take personal responsibility for my rehabilitation and treatment and I will actively participate in this treatment plan that has been developed by my treating provider

I authorise

- The collection and disclosure of any information about me to the extent necessary to determine/assess my entitlement including treatment
- The treatment provider to lodge this request for treatment on my behalf and understand that further treatment is subject to prior approval by ACC

Patient's signature Date / /

SECTION 7: CERTIFICATE, SIGNATURE AND TREATMENT START DATE

This treatment is for the personal injury for which the claimant has cover and:

- is for the purpose of restoring the claimant's health to the maximum extent practicable, and
- the treatment is necessary and appropriate, and of the quality required, for that purpose.

I have discussed the treatment options with the claimant and advised why the recommendation is the appropriate treatment in this case.

Provider's signature Date / /

The information collected on this form will only be used to fulfil the requirements of the Injury Prevention, Rehabilitation, and Compensation Act 2001. In the collection, use and storage of information, ACC will at all times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code 1994.

Request for Prior Approval of Treatment

ACC32 number **M12345**

“Treatment providers complete this form to request and validate ongoing treatment on behalf of the patient or to request an alteration in diagnosis.”



Please indicate:

- Additional diagnosis only
- Additional diagnosis plus treatment
- Treatment only
- Change in diagnosis only
- EPN Provider
- ACC32A
- ACC32R

SECTION 1: CLAIMANT DETAILS

ACC45 number _____ or Claim number _____

Claimant's name _____

Date of birth _____ Date of injury _____

Claimant's address _____

Occupation _____ Telephone _____

SECTION 2: TREATMENT DETAILS

Read Code(s) _____ Treatment Profile Recommended number of treatments _____

Read Code(s) to be added _____

Number of treatments given to date _____ Number of additional treatments requested _____

EPN Providers indicate number of treatments at PT02 _____ PT04 _____

Assessment required (only after 52 weeks): PT01 _____ PT03 _____ TMTI _____

SECTION 3: PROVIDER DETAILS

NAME OF TREATING PRACTITIONER/ADDRESS OR STAMP AND PROVIDER STAMP _____

Provider type _____

ACC Provider number _____

Telephone _____

SECTION 4: HISTORY, EXAMINATION AND DIAGNOSIS

Initial diagnosis _____

How did the injury occur? _____

Current diagnosis (include a precise description of the current condition and where appropriate the reason for a change of Read Code) _____

Explain how the current condition has been caused by the covered injury _____

Why has the condition not resolved within the treatment profile trigger number/treatment limit or within the expected timeframe? (Include pre-existing factors.) _____

SECTION 5: CURRENT STATUS, MANAGEMENT AND PROGNOSIS

List measurable goals achieved as a result of treatment to date (if the patient has been treated at your clinic)

A) Signs and Symptoms	B) Function

List current measurable limitations (from this injury)

A) Signs and Symptoms	B) Function

Goals (current, specific and measurable)	Treatment plan (include self-management)	Expected Timeframe (include treatment frequency)
A) Signs and Symptoms		
B) Functional		

Please attach relevant medical information (e.g. x-ray reports, medical notes)

Recommendation for further management if current treatment goals not met? _____

SECTION 6: PATIENT DECLARATION

I declare

- That the information (including personal details) on this form is true and correct
- I accept that I have to take personal responsibility for my rehabilitation and treatment and I will actively participate in this treatment plan that has been developed by my treating provider

I authorise

- The collection and disclosure of any information about me to the extent necessary to determine/assess my entitlement including treatment
- The treatment provider to lodge this request for treatment on my behalf and understand that further treatment is subject to prior approval by ACC

Patient's signature _____

Date _____

SECTION 7: CERTIFICATE, SIGNATURE AND TREATMENT START DATE

This treatment is for the personal injury for which the claimant has cover and:

- is for the purpose of restoring the claimant's health to the maximum extent practicable, and
- the treatment is necessary and appropriate, and of the quality required, for that purpose.

I have discussed the treatment options with the claimant and advised why the recommendation is the appropriate treatment in this case.

Provider's signature _____

Date _____

The information collected on this form will only be used to fulfil the requirements of the Injury Prevention, Rehabilitation, and Compensation Act 2001. In the collection, use and storage of information, ACC will at all times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code 1994.