

Request for prior approval of treatment

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 TI	reatment only Additional diagnos	sis plus treatment Additional diagnosis only				
SECTION 1 - PATIENT DETAILS			List current measurable limitations (from this injury)			
ACC45 number		OR ACC claim number	A) Signs and symptoms B) Functions			iction
Date of injury	DD MM YYYY					
First name(s)		NHI number				
Last name						
Postal address	Street		Goals (current, specific and measurable)	(Treatment plan (include self-management)	Expected timeframe (include treatment frequency)
	Suburb	Gity + Postcode	A) Signs and symptoms		metade seq managementy	(metade treatment frequency)
Date of birth		ipation	79 Signs and Symptoms			
Phone	WORK Area code Number	HOME/ Code				
Email address	0 1 1 1 1 1	HOME/ Code O				
			B) Functional	I		
SECTION 2 - TREATM	MENT DETAILS					
Read code(s)						
Treatment profile	Number given to	of treatments	Please attach relevant medical informati	on (e.g. x-ray reports, medic	cal notes)	
Number of additional	Regulation PT02	O PT01 O PT05	Recommendation for further management if		,	
treatments requested	Hand 1 Hand 2	Splinting of hand \$				
READ CODE(S) TO BE ADDE		(Complete the first four sections of Section 4 and attach				
KEAD CODE(S) TO BE ADDE.		supporting clinical notes)	SECTION 5 - PATIENT DECLARATION	O N		
		tion of the current condition and if appropriate, why the current diagnosis differs from the med at the time of claim lodgement)	 that the information given in this form is tru I have not withheld any information likely to I will inform ACC of any change in circumsta my entitlements. I authorise:	o affect my application. nces which may affect ta re to use and disclose it the	laim etails of my accident	s and history which are or may be
			Patient's signature		Da	ate DD MM YYYY
		esented today, or the new Read code being added, is related to the				
covered injury (a causal link n	needs to be established in order for ACC to consider if the	e condition requiring treatment is related to the covered injury)	SECTION 6 - PROVIDER DECLARA	TION		
			Name of treating practitioner/address or stamp and provider stamp		Provider	
					type ACC P	Provider ID
					ACC	Vendor ID
(include pre-existing factors)	of resolved within the freatment profile tr	rigger number/treatment limit or within the expected timeframe?				
			Phone Area code Number	Provider email		
	NT STATUS, MANAGEMENT AND I		This treatment is for the personal injury for whi	sary, appropriate, and of the o	quality required for this purpos	se.
	igns and symptoms	B) Function	I have discussed the treatment options with the Provider's name	e patient and advised why the	e recommendation is the appro	opriate treatment in this case.
7,9	- July and Cymptonio		1 Torrido: 5 Hume	PI	Please print clearly	
			Provider's signature		Da	ate DD MM YYYY
		·				

The information collected on this form will only be used to fulfil the requirements on the Accident Compensation Act 2001. In the collection, use, disclosure, and storage of information Act 2020, the Health Information Privacy Code 2020 and the Official Information Act 1982.

Request for prior approval of treatment

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	Treatment only O Additional diagnosis plus treatment O Additional diagnosis only				
SECTION 1 - PATIEN		List current measurable limitations (from this injury)			
ACC45 number	OR ACC claim number	A) Signs and symptoms		B) Function	
Date of injury	DD MM YYYY				
First name(s)	NHI number				
Last name					
Postal address	Street	Goals (current, specific and measurable)	Treatment plan (include self-management)	Expected timeframe (include treatment frequency)	
	Suburb Gity + Postcode	A) Signs and symptoms	(metade set, managemens	(metade treatment prequency)	
Date of birth	DD MM YYYY Occupation	y cigno and cynip conc			
Phone	WORK				
Email address	O MOBILE O M				
SECTION 2 - TREAT	MENT DETAILS	B) Functional			
Read code(s)					
Treatment profile	Number of treatments				
	given to date	O Please attach relevant medical information			
Number of additional treatments requested	Regulation PT02 PT01 PT05	Recommendation for further management if tre	eatment goals not met?		
	Hand 1				
READ CODE(S) TO BE ADDE	(Complete the first four sections of Section 4 and attach supporting clinical notes)				
SECTION 3 - HISTO	RY, EXAMINATION AND DIAGNOSIS	SECTION 5 - PATIENT DECLARATION I declare:			
Initial diagnosis		• that the information given in this form is true a		ds which are or may be relevant to my	
		I have not withheld any information likely to aff I will inform ACC of any change in circumstance			
How did the injury occur	.2	my entitlements.	,	t details and history which are or may be	
Trow and the mjury occur	:	l authorise:	relevant to my claim		
		 ACC to collect the following information and to in accordance with the purposes set out above 		rmation to provide it to ACC	
Current diagnosis or new	v additional diagnosis (include a precise description of the current condition and if appropriate, why the current diagnosis differs from the es, provide a full explanation of why these were not confirmed at the time of claim lodgement)	Privacy Policy:	the fleatment provider t	o todge tills etalli for me	
ongmai mjarji rom neda eede	saproma a full aspaination of this accentification, interest and a full attention of the full accentification of t				
		Patient's signature		Date DD MM YYYY	
•	on as to why you think the condition as presented today, or the new Read code being added, is related to the reeds to be established in order for ACC to consider if the condition requiring treatment is related to the covered injury)				
	, , , , , , , , , , , , , , , , , , , ,	SECTION 6 - PROVIDER DECLARATION Name of treating practitioner/address or stamp and provider stamp	Provider		
		, , , , , , , , , , , , , , , , , , , ,	type	ACC D L ID	
				ACC Provider ID	
	ot resolved within the treatment profile trigger number/treatment limit or within the expected timeframe?			ACC Vendor ID	
(include pre-existing factors)					
		Phone Area code Number	Provider email		
SECTION 4 - CURRE	ENT STATUS, MANAGEMENT AND PROGNOSIS	This treatment is for the personal injury for which the maximum extent practicable, and is necessary			
List measurable goals ac	chieved as a result of treatment to date (if the patient has been treated at your clinic)	I have discussed the treatment options with the p			
A) S	Signs and symptoms B) Function	Provider's name First name	Last name		
		Drovidor's signature	Please print clearly	Data DD LIM DAAY	
		Provider's signature		Date DD MM YYYY	

The information collected on this form will only be used to fulfil the requirements on the Accident Compensation Act 2001. In the collection, use, disclosure, and storage of information, ACC will at all times comply with the obligations of the Privacy Act 2020, the Health Information Privacy Code 2020 and the Official Information Act 1982.

Request for prior approval of treatment

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	Treatment only O Additional diagnosis plus treatment O Additional diagnosis only			
SECTION 1 - PATIE		List current measurable limitations (from this injury) A) Signs and symptoms	B) Func	tion
ACC45 number	OR ACC claim number	A) Signs and Symptoms	B) runc	LUON
Date of injury	DD MM YYYY			
First name(s)	NHI number			
Last name				
Postal address	Street	Goals	Treatment plan	Expected timeframe
	Suburb City + Postcode	(current, specific and measurable) A) Signs and symptoms	(include self-management)	(include treatment frequenc
Date of birth	DD MM YYYY Occupation	A) Signs and symptoms		
Phone	WORK Towns Towns			
	Area code Number O MOBILE O O O O O O O O O O O O O O O O O O O			
Email address		B) Functional		
SECTION 2 - TREAT	TMENT DETAILS	B) Functional		
Read code(s)				
Treatment profile	Number of treatments			
Number of additional	Regulation PT02 PT01 PT05	O Please attach relevant medical information (e.g. x-ray		
treatments requested		Recommendation for further management if treatment go	oats not met:	
	Hand 1 Hand 2 Splinting of hand \$			
READ CODE(S) TO BE ADD	OED (Complete the first four sections of Section 4 and attach supporting clinical notes)			
SECTION 3 - HISTO	ORY, EXAMINATION AND DIAGNOSIS	SECTION 5 - PATIENT DECLARATION I declare:		
How did the injury occu Current diagnosis or new original injury. For new Read cod	ar? The wadditional diagnosis (include a precise description of the current condition and if appropriate, why the current diagnosis differs from the class, provide a full explanation of why these were not confirmed at the time of claim lodgement)	 I have not withheld any information likely to affect my app I will inform ACC of any change in circumstances which may entitlements. I authorise: ACC to collect the following information and to use and di in accordance with the purposes set out above and in ACC Privacy Policy: 	 details of my accident tax records, employment details relevant to my claim the holders of such information to the ho	to provide it to ACC
		Patient's signature	Dat	e DD MM YYYY
Provide a full explanation	on as to why you think the condition as presented today, or the new Read code being added, is related to the			
covered injury (a causal line	nk needs to be established in order for ACC to consider if the condition requiring treatment is related to the covered injury)	SECTION 6 - PROVIDER DECLARATION		
		Name of treating practitioner/address or stamp and provider stamp	Provider	
			typeACC Pro	ovider ID
Why has the condition r (include pre-existing factors)	not resolved within the treatment profile trigger number/treatment limit or within the expected timeframe?		ACC V	endor ID
		Phone Area code Number O Number Pro	ovider email	
SECTION 4 - CURR	ENT STATUS, MANAGEMENT AND PROGNOSIS	This treatment is for the personal injury for which the patient		
	achieved as a result of treatment to date (if the patient has been treated at your clinic)	the maximum extent practicable, and is necessary, appropria		
	Signs and symptoms B) Function	I have discussed the treatment options with the patient and Provider's name	Last name	priate treatment in this case.
		Provider's signature	Please print clearly Dat	e DD MW JYYYY

Important information

PATIENT

Collecting and using your personal information

ACC collects your personal and health information to assess whether your claim is covered under the ACC scheme, to manage your claim, and to assess and provide appropriate rehabilitation, treatment, and compensation to you. We also use personal information for other lawful purposes connected with our functions and activities under the Accident Compensation Act 2001 (including research, policy development, maintaining a claims database, systems testing, levy setting, internal processes including investigations, training and processing information requests).

ACC may need to obtain medical and other records about you from third parties such as your general practitioner (GP), specialists, other medical professionals or treatment providers, or your employer.

Providing information to ACC is voluntary. However, if relevant information is not provided, ACC may not be able to determine whether you are eligible for cover or for particular entitlements. Under the Accident Compensation Act 2001, you must provide information that is relevant to your claim when ACC reasonably requires you to provide it.

ACC may decline to provide any entitlement if you unreasonably refuse to give ACC any relevant information or to authorise ACC to obtain records that may be relevant to your claim.

ACC shares personal and health information with other agencies for the purposes of managing claims and entitlements, to fulfil our other statutory functions, and in other situations where permitted or required by law. These agencies include government agencies, external providers (e.g. treatment providers) and your employer (including for non-work related injuries).

You have the right to access and request correction of personal and health information that ACC holds about you.

The Privacy Act 2020 and the Health Information Privacy Code 2020 apply to your personal and health information. Further details of how and why we collect, use, store and disclose information are set out in our Privacy notice which may be viewed on our website: https://www.acc.co.nz/privacy/our-privacy-notice/.

For more information about privacy, to request access or correction of your personal and health information, or if you have a question or concern, contact us: privacy.officer@acc.co.nz

The Privacy Officer
Accident Compensation Corporation
PO Box 242
Wellington 6011