

Information for treatment providers

The following 2 pages provide notes on how to complete the revised ACC45 Injury Claim Form.

This form has been redesigned to A4 size in response to requests from providers for a smaller-sized form.

If Form Too Small

Some patients may find this form too small to read easily. In that situation, please use the existing, larger-sized “blue” ACC45 Injury Claim Form.

Providers Using eLodgement

If you submit claims electronically, but you want a claim form for your patients to complete, please order ACC46 Pro-Forma Injury Claim Forms from our forms supplier (call 0800 802 444).

These single-copy forms are available in pads of 25 forms. They are not numbered, since your PMS system will issue the ACC45 number when the claim is entered. The forms are for your records, only, and will not be accepted by ACC (since you will be sending the claim information electronically).

Re-ordering ACC45 Forms

If you need more ACC forms, please call our forms supplier on 0800 802 444.

Provider Inquiry Centre

If you need help in completing these forms, please call us on 0800 222 070.

Check for Form Completeness before Sending ACC45 to ACC

Please make sure the form has been completed correctly before you send it to ACC. In particular, make sure the patient (or their authorised representative) and the provider have signed the form. Without those signatures, ACC cannot process the claim and the form will be returned to you for correction.

Send Completed ACC45 Forms to ACC on the Day of Treatment

Please send completed forms to ACC on the day of treatment in the post-paid envelope. We process claims on the day received and contact those patients who need assistance.

This also speeds up the processing of payments to providers.

ACC45 Injury Claim Form

Guide to form completion
(as at December 2001)

Parts A,B & C: Patient Information

For further information about form completion, please call 0800 222 070

ACC 45 ACC Injury Claim Form
Patient to complete

Te Kaporeihana Āwhina Hunga Whara
PREVENTION. CARE. RECOVERY.

PART A: PERSONAL DETAILS

Family name (SURNAME) _____
First name(s) _____
Date of birth (DAY MONTH YEAR) _____ Male Female
Home/postal address (NUMBER STREET NAME SUBURB TOWN/CITY) _____
Telephone Work CODE _____ Home CODE _____

What is your ethnic background? *This information is collected for statistical reasons only, to help ACC develop services that are culturally appropriate.*
 NZ European/Pakeha Cook Island Maori Fijian Indian Samoan Other ethnic group – please specify: _____
 Other European Tongan Other Pacific Other Asian Tokelauan
 NZ Maori Niuean South East Asian Chinese I'd prefer not to say

PART B: ACCIDENT & EMPLOYMENT DETAILS *If required, you can provide further information in answer to the following questions on a separate sheet of paper*

When did the accident happen? (DAY MONTH YEAR) _____ at (TIME) _____ am pm
Accident scene (e.g. home, place of work, road) _____
Accident location (e.g. Taupo) _____ Did the accident occur in New Zealand? Yes No
What were you doing – what happened – how was the injury caused? (e.g. cleaning kitchen, slipped on wet floor and hit head on table) _____
Did the accident involve a moving vehicle on a public road? Yes No If sporting injury, name sport (e.g. rugby union) _____
Occupation Please tick those that apply: I work part-time or full-time I own /part own the company in which I work I am self-employed I am not employed
What type of work do you do? Sedentary (brief standing and walking) Light (mainly standing and walking) Medium (often lift 5kg plus) Heavy (often lift 9kg plus) Very Heavy (often lift 22kg plus)
Did the accident happen at work? Yes No
What is the name of the business you are employed by/own? _____
What is the address of the business you are employed by/own? _____

PART C: PATIENT DECLARATION

I have read and understood the important Patient Information and Patient Declaration on the reverse of the patient copy of this form.

Patient to sign here or legal guardian or representative _____ Date (DAY MONTH YEAR) _____
Authorised representative's name _____ Authorised representative's relationship to patient _____

Please also give previous surname if changed in the past few years

Accurate name, address and date of birth information enables ACC to link new claims to previous claimant records

ACC calls many claimants. Accurate information assists in making contact quickly

These questions help ACC to decide how this claim will be paid for. Injuries involving a moving vehicle on a public road are paid for by the ACC motor vehicle levy & excise

Employers pay for work claims (including claims for shareholder employees.) Self-employed people pay for work claims to the self-employed. The government pays for claims from people who are not in employment Earners pay for non-work claims (e.g. home, sport) from earners, self-employed & shareholder employees.

The patient signature, in conjunction with the patient declaration on the reverse of the form, authorise the provider to lodge the claim with ACC and to release information to ACC and its agents

ACC collects ethnicity data to ensure that it can provide services that are culturally appropriate

ACC uses this information to determine whether the claim can be accepted and to derive statistical data about the causes of injuries

Occupation information helps ACC to estimate the impact of injuries on individuals in particular occupations

If this injury happened at work & the employer is accredited, send the claim form and your invoice to the employer. ACC does not pay for accredited employer claims

The employer name & address is required for all work injuries (ACC must notify the employer) and all non-work injuries that involve time off work (ACC contacts the employer about earnings data & job protection)

The form must be signed and dated before it can be accepted by ACC

ACC45 Injury Claim Form

Guide to form completion
(as at December 2001)

Parts D,E & F completed by
Treatment Providers

For further information about
form completion, please call
0800 222 070

ACC requires one or more diagnosis codes using Read, ICD9 or ICD10 (please indicate which one is used)

See the addresses on the back of this form for Medical Misadventure & Sensitive Claims

Tick "Yes" if the patient will need further assistance from ACC such as home help or case management. Tick "No" if the patient just needs simple medical or referred treatment without other assistance from ACC

If the patient is able to return to work on restricted duties, please indicate the number of days and the nature of the restriction

Note that only a Registered Medical Practitioner can certify a patient as fully unfit for work or able to undertake restricted duties

ACC Provider number, name, signature & date must be completed before the form can be accepted by ACC

Check this website for a list of accredited employers

Please consider the suitability of restricted duties for patients, if this is appropriate, instead of being fully unfit for work

Treatment Provider to complete
Note: ACC does not provide cover for illness or sickness.

XX12345

PART D: INJURY DIAGNOSIS AND ASSISTANCE

Patient's NHI no. []

Diagnosis coding used if not READ CODES ICD9 ICD10

Diagnosis 1 [] Side: Left Right

Diagnosis 2 [] Side: Left Right

Diagnosis 3 [] Side: Left Right

Is this a Gradual Process Injury? Yes No

Additional injury comments to injury code entered above []

Is this claim for medical misadventure? Yes No

Referral information (type of Treatment Provider referred to)

Physio Other referral/ treatment objectives: []

X-ray

OTHER REHABILITATION ASSISTANCE REQUIRED (e.g. case management or home help):

ACC should call patient? Yes No ACC should call me? Yes No

PART E: WORK CAPACITY *Registered Medical Practitioner only to complete this part*

IS THE PATIENT ABLE TO CONTINUE NORMAL WORK? Yes (go to part F) No (continue)

RESTRICTED DUTIES: The patient is able to undertake restricted duties

for [] days, from [] DAY [] MONTH [] YEAR of the following type:

Sedentary (brief standing and walking) Light (mainly standing and walking) Medium (often lift 5kg plus) Heavy (often lift 9kg plus)

Additional restrictions (e.g. up to four hours per day; no lifting) []

FULLY UNFIT: The patient is unfit for work for [] days, from [] DAY [] MONTH [] YEAR

REVIEW/RETURN TO WORK: Based on this medical assessment

a review is required on, or [] DAY [] MONTH [] YEAR

the patient should be fit to return to normal work on: [] DAY [] MONTH [] YEAR

PART F: TREATMENT PROVIDER DECLARATION

I certify that, on the date shown, I have personally provided the services as specified above and that in my opinion the condition is the result of an accident.

ACC PROVIDER NUMBER []

National Provider Index

Treatment provider name (print) or stamp []

Treatment provider signature []

Date [] DAY [] MONTH [] YEAR

ACC or Accredited Employer copy: please return this form when completed to your ACC Service Centre or to the Accredited Employer (check www.acc.co.nz).

11/01

Quote this ACC45 Claim Form number if you call ACC about this claim

NHI Number, if known

Tick "Yes" if this is a work-related gradual process injury. (Note that ACC does not provide cover for non-work gradual process injuries)

Tick "Yes" if you want an ACC case manager to call you about the claim

You only use the rest of this panel if the patient is unable to continue normal work (i.e. can perform restricted duties or is fully unfit for work)

Indicate whether the next event is a return to work or a follow-up visit to review the injury. Then give the date of that follow-up or expected return to work.

National Provider Index not yet required



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Accident Compensation Corporation

Phone 0800 222 776

www.acc.co.nz

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