He Kaupare. He Manaaki. He Whakaora.
prevention. care. recovery.

28 July 2023

[redacted]

Kia ora [redacted]

Your Official Information Act request, reference: GOV-026247
Thank you for your emails of 5 and 17 July 2023, asking for the following information under the Official Information Act 1982 (the Act):

1. *ACC's claims lodgement policy, to include information around lodging proxy claims for cover.* (5 July 2023)

You clarified your request as follows:

I'm looking for information and/or policy documents to cover off the following scenarios:
1. *Can proxy requests be made by internal staff for a new claim to be lodged manually, which does not have a claim form / ACC18?* ***AND***
2. *Can an additional diagnosis be added to an existing claim by 'proxy', which does not have a claim form / ACC18?* ***AND***
3. *Per ACC's policy and the legislation in place e.g. ACC Act 2001 - Can an ACC staff member action a 'proxy request' for cover in circumstances where the* ***claimant and/or their delegated support person / representative*** *requests an ACC staff member to 'lodge' a claim by 'proxy' on a claimants behalf,* ***AND*** *ACC is in receipt of a recent medical report from a leading specialist confirming a diagnosis, that is yet to be lodged to either a new claim, or as an additional diagnosis to an existing claim?*
   On this basis, would it be necessary for a client to visit his or her GP to lodge a claim at the claimants own expense, if ACC can lodge a claim instead by 'proxy', should a specialist report confirm a specific diagnosis?
4. *Specifically In what circumstances can an ACC staff member lodge a proxy request for cover?* (17 July 2023)

We do not use the terms 'proxy' or 'proxy requests' to describe a particular way of lodging a claim for cover. However, noting the clarification you provided, we have interpreted your request as referring to claims that a client or their representative have lodged directly with ACC. We refer to these as manual claims. The attached documents provide information on how ACC manages such claims, and include:

- Receive and Input Manual Claim: New claim lodgement with no claim form
- Assess Cover for an Additional Injury or Change in Diagnosis
- Claim Lodgement
- Client lodgement methods (Business Rule)
- Authorised representative lodgement methods (Business Rule)
- Claim lodged using claim form (Business Rule)

As staff names were not requested, they have been deemed out of the scope of your request and removed from the documents provided.

A client or their authorised representative can contact ACC to lodge an initial claim for cover. The Lodgement Administrator will then assess whether they have enough information to register the claim, or whether more should be requested. See the note under section 1.0(d) in '*Receive and Input Manual Claim: New claim lodgement with no claim form.'*

If the request for lodgement is related to adding or changing a diagnosis of an existing claim, the treating provider must make the request. See *'Assess Cover for an Additional Injury or Change in Diagnosis'* and the first and third notes under section 1.0(a), which show that if new medical information is received, a formal request for a change of diagnosis from the treating provider needs to be made.

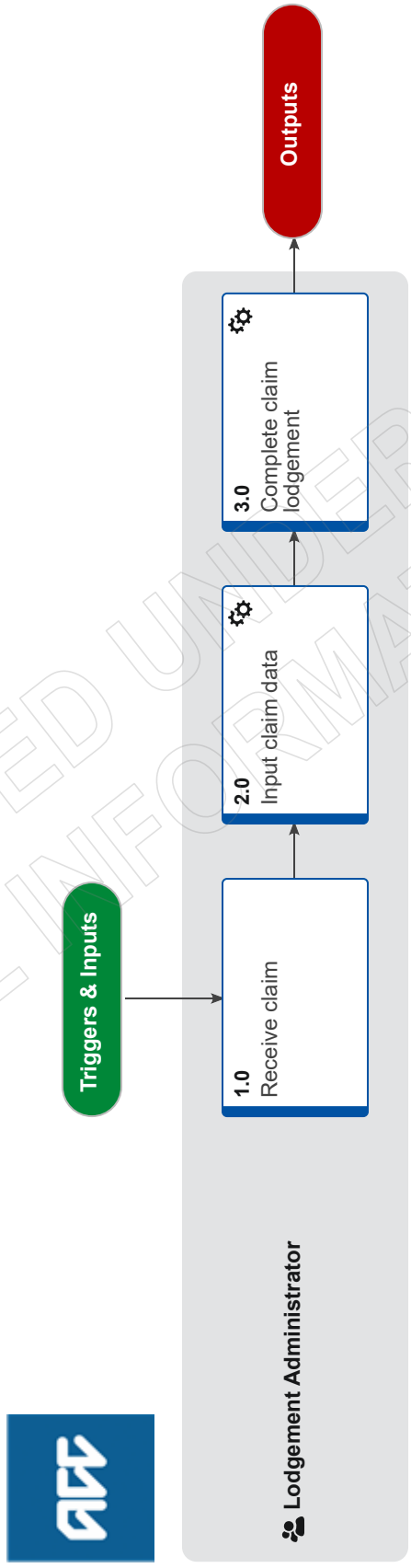
As this information may be of interest to other members of the public
ACC may decide to proactively release a copy of this response on ACC's website. All requester data, including your name and contact details, will be removed prior to release. The released response will be made available www.acc.co.nz/resources/#/category/12.

If you have any questions about this response, please get in touch
You can email me at GovernmentServices@acc.co.nz.

Ngā mihi

Sara Freitag
Acting Manager Official Information Act Services
Government Engagement

Receive and Input Manual Claim :: New claim lodgement with no claim form v14.0



Receive and Input Manual Claim :: New claim lodgement with no claim form v14.0

Summary

Objective
To capture new claims requested by internal staff into Eos and file the relevant information

Background
In certain circumstances it's necessary to create a new claim In these cases, there will be no standard ACC claim form so the information must be provided another way

Global Process Owner [Out of Scope]

Global Process Expert [Out of Scope]

Variation Expert [Out of Scope]

Procedure

1.0 Receive claim

Lodgement Administrator

a Open the Registration Email Inbox and access the new claim request.

b Read the email content and any attachment(s).

NOTE **What if the email doesn't have all the information I need?**
Reply to the email and request the information from the sender.

c Confirm that the request meets the criteria for a new claim to be lodged

NOTE **What's the criteria for a new claim to be lodged?**
A new claim may be lodged only if all of the following are true:
• The client has consented to the new claim being lodged via any of the following methods:
o verbally
o in writing
• and at least one of the following is true:
o the date of accident of the new claim is different from the date of accident of the claim that the client is currently being treated for
o the accident description of the new claim is different from the accident description of the claim that the client is currently being treated
o the claim contains at least one of the following types of claim:
 complicated claim
 non-complicated claim

Non-complicated claim definition

Complicated claim definition

NOTE **What if the claim doesn't meet the criteria for a new claim?**
Return the request to the requestor for them to gather more information or cancel the request

d Confirm that you have all the information you need to register a new claim

NOTE **What information do I need to register the claim?**

A request for a new claim must contain all of the following information relating to the client:
- Person ID
- First name of client
- Surname of client
- Date of birth of client
- NHI number of client
- Fund code of new claim
- Accident description of new claim
- Date new injury identified
- Provider name
- ACC provider number
- Full name of the person submitting the request for a new claim
- Title of the person submitting the request for the new claim
- Date the request for a new claim was submitted
- The name of the ACC business unit submitting the request for a new claim
- The ACC45 number of the original claim, if there is one
- The name of the staff member if the new claim needs to be transferred to a specific person
- At least one of the following for the new claim:
  - o read code
  - o injury description
  - o injury diagnosis
- A copy of at least one of the following:
  - o Document where the injury is recorded
  - o Clinical notes with the relevant page number noted
  - o Instruction from the Technical Services team
  - o Medical Advisor comment

NOTE **A request for a new claim may be on the Referral for new claim lodgement form**

Referral for New Claim Lodgement

NOTE **What if the email doesn't have all the information I need?**

Reply to the email and request the information from the sender.

NOTE **What if the email is from MFAT (Ministry of Foreign Affairs & Trade) or an Embassy?**

If the email is from a staff member posted overseas, we still need to register their claim.
We will also register claims on behalf of their family members – usually the email will still come from the MFAT staff member

- Lodge the claim using a dummy number

- If there is insufficient information on the email from the client regarding their personal details (eg. Date of birth, Middle name etc.), Please respond to the email and get clarifying details.

If the client has not attached enough information about the accident – please clarify this, this could be done by requesting a medical certificate or doctors notes to show they have sought treatment.

If the client has supplied an address, then please update their details otherwise leave all information as it is.

- Let the claim stream to Cover Triage for assessment and suppress the letters

2.0 Input claim data

Lodgement Administrator

a In Eos, open the client's party record. See the Client Searches guide below.

Client searches

b Turn off notifications.

Stop notifications

c Request a Dummy ACC45 number using the Request Dummy 45 tool.

Request Dummy 45 spreadsheet

d In the reason for request box in the Request Dummy 45 tool, type: 'Referral for new claim lodgement'

e In Eos, enter the new claim information into the relevant fields.

NOTE **What if it's been identified that it's a work related gradual process, disease or injury?**

Add 'WRGP' to Additional Injury Comments to ensure that it streams to the Gradual Process team.

f In Part E, enter the default provider number (J99966) so that the claim receives a Held cover status.

g Click NEXT on the claim intake form to save the changes.

h Reopen the new claim and action any information requirements.

i Once the claim has a 'Registration Complete' status, remove the default provider and replace with the actual provider from the ACC45.

NOTE **What if the claim has been streamed to a specialist department?**
Transfer the claim to your queue (or contact the relevant department to ask for it to be transferred to your queue if you're not able to transfer it yourself).

j In Eos, upload any documents that came with the request to the claim.

File an inbound email

NOTE **What document type should I use in Eos?**
- Miscellaneous claims: VCF011 Internal document
- Sensitive claims: SC VCF011

NOTE **What information should I include when I'm uploading and where?**
- Contact details: Referral for new claim lodgement
- Status: Received
- Direction: Internal
- Reason: Contact with Internal Party
- Description: Referral for new claim lodgement

k Confirm cover status
- If meant to be Held, then transfer to relevant person or team.
- If meant to be Accept, then amend cover status to Accept and suppress auto accept letter.

l Open the client's party record and turn notifications on.

m Confirm to the requestor that you've created the new claim and advise of any changes or default info you had to use.

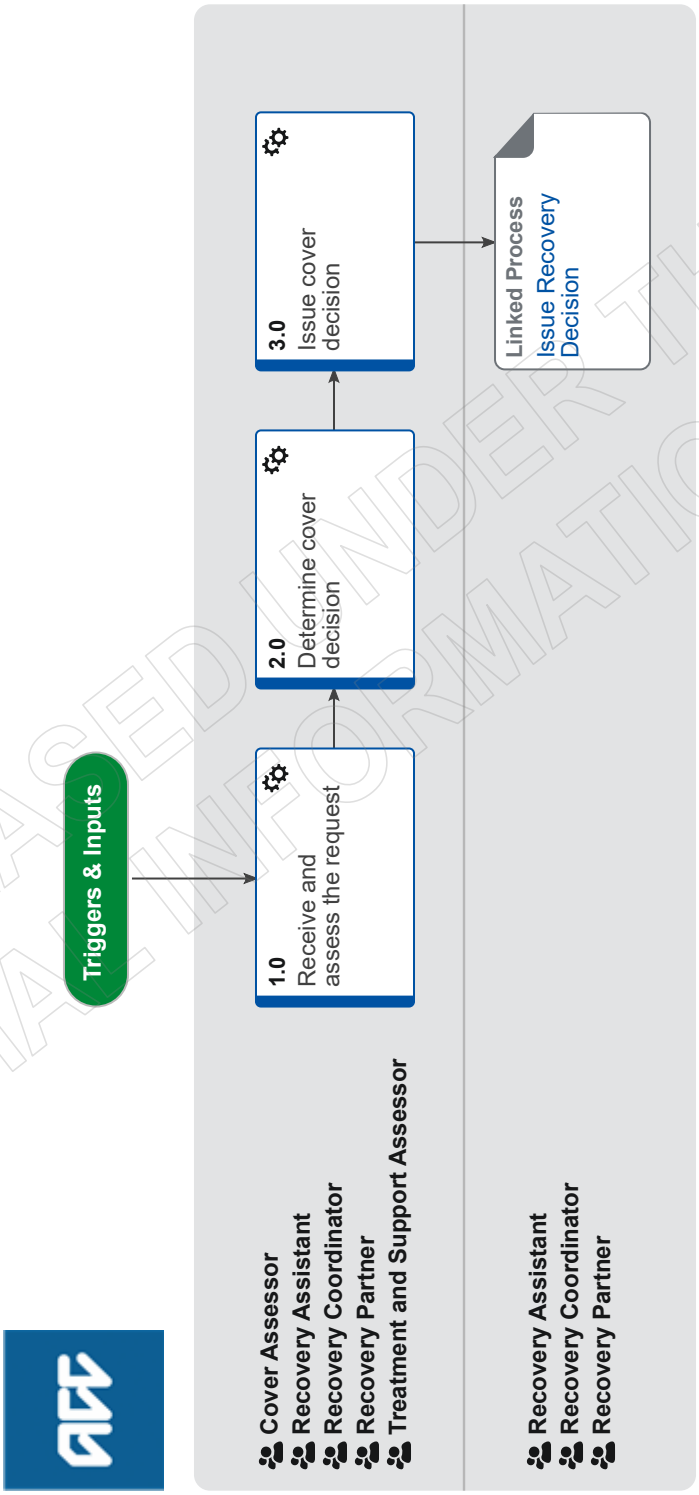
3.0 Complete claim lodgement

Lodgement Administrator

a Close out of the Eos screen and any related documents.

b Move email into Completed [current year] sub-folder in the Registration Email Inbox.

Assess Cover for an Additional Injury or Change in Diagnosis v34.0



Assess Cover for an Additional Injury or Change in Diagnosis v34.0

Summary

Objective
The objectives of the process are:
• to assess the 'new injury' against cover criteria, so that the client can request supports.
• to action information about the 'new injury', so that ACC has accurate information about the client's injuries.
• to re-assess client's needs, so that the recovery pathway can be managed appropriately.

Background
Providers usually change or add a diagnosis if they made a mistake on the original claim form or have completed further diagnostics and assessments from which they identified new symptoms. The additional or changed diagnosis is referred to as the 'new diagnosis' or the 'new injury' in the context of this process, while the diagnosis provided on ACC45 is referred to as 'original diagnosis' or 'original injury'.

If the 'new injury' is different comparing to the 'original injury', we will assess cover for the 'new injury'. This is because clients might want to request entitlement(s) and support(s) to help recover from their injury, but ACC can only approve entitlements and supports for the injuries that have been granted cover.
The Accident Compensation Act 2001 allows providers (on behalf of clients) and clients to submit:
• a stand-alone request (claim) for cover
• a request (claim) for cover and treatment (or other supports) at the same time

The 'new injury' can be encountered at any stage of the recovery pathway. The following teams are responsible for assessing the 'new injury' for cover:
• Cover Assessment teams: claims that are not actively managed, ie claims are in Actioned Cases department.
• Assisted, Supported and Partnered Recovery: if there is actively managed claims within these teams
• Treatment & Support Assessment: when there is a request for cover and treatment at the same time.

Owner [Out of Scope]

Expert

Procedure

1.0 Receive and assess the request

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner, Treatment and Support Assessor

a Review the information for an additional injury or change in diagnosis. This can be via any of the following documents:
• an ACC18 Medical Certificate.
• an ACC554 Medical Certificate with permanent impairment.
• an ACC125 additional information on diagnosis.
• A request from the client's treating provider (eg letter from provider, Surgical ARTP).
• an ACC2152 Treatment Injury Claim.
• ACC32 Treatment Extension Request.

NOTE **What if you receive a request via MyACC - task NGCM - Request Change in Claim Information?**
Contact the client and advise that they need their treating provider to formally lodge a request.

NOTE **What if you are unsure if you have a request for additional cover?**
If the request is within the timeframes for assessing cover, clarify with the lodging provider if there is a request for an additional injury or change in diagnosis.
If the request is not within the timeframes for assessing cover, refer to Technical Services for guidance following the Seek Internal Guidance process.
PROCESS Seek Internal Guidance

NOTE **What if new medical information is received and excluded from above list?**
We consider all new medical information received on a claim. ie Clinical notes, Specialist reports, MRII's/Xrays). This information does not always constitute an additional injury or change in diagnosis cover request unless there is an explicit request from the treating provider.

If that information would change the current diagnosis (but is not explicitly requested) then we may seek a change or request via their treating provider who would complete an ACC18 or ACC32 and submit to ACC for consideration.

NOTE **What do you need to consider when the entitlement request is received and deemed cover exists?**
Refer to the Deemed Cover and Entitlements Policy for considerations to determine client entitlement eligibility while in deemed cover period.

Deemed Cover and Entitlements Policy

NOTE **What if the client, provider, or advocate has called and advised ACC verbally of the request?**
Inform the party that the request needs to be in writing, advise them to go to the ACC website for more information.

b Check you have all of the minimum required information on the request:
- the injury diagnosis (code and description).
- the body site of the injury (if applicable).
- the date of accident or event (in which the person was injured).
- short description of why adding or changing a diagnosis.

NOTE **What if information is missing?**
Contact the provider to clarify if this is a request for an additional diagnosis or change in diagnosis and obtain the missing information.

c Confirm the client has an accepted claim.

NOTE **What if the request is for a new event?**
A new claim must be lodged.
- ensure it's appropriate to lodge a new claim without the client seeing an ACC registered provider
- call the client and get verbal authority to register a new claim.
- complete the Referral for New Claim Lodgement form. In the section 'Transfer Claim To', write your name and team details. If this claim is a WRGP injury, write - Work related Gradual Process Queue
- email the completed form to Hamilton.Registration@acc.co.nz

PROCESS Consequential Injury Claims Policy

Referral for New Claim Lodgement

NOTE **What if the request is for a possible Work Related Gradual Process injury?**
Contact the Work Related Gradual Process team on huntline 87815 to discuss and ensure it is appropriate to lodge a new claim and to help manage expectations

NOTE **What if the claim is for a physical injury and has cover status of 'held'?**
Refer to Assess Claim for Cover :: with variations process.

PROCESS Assess Claim for Cover :: Simple PICBA claim

NOTE **What if this is for a Treatment Injury?**
All Treatment Injury claims are assessed via a Treatment Injury Cover assessor. In Eos, create a General Task with the additional diagnosis, set the priority to 'High' and transfer the task to the TIC Administration queue.

NOTE **What if the request for additional cover is for hearing loss on a claim in actioned cases.**
Transfer the claim to the hearing loss queue.

NOTE **What if the request for additional cover is for hearing loss and the claim is with a recovery team.**
If the request is for an additional diagnosis relating to hearing loss it needs to be tasked to 'Hearing loss claims'

NOTE **What if it's a request for cover for Mental Injury caused by Physical Injury?**
Refer to Make Cover Decisions for Mental Injury Caused by Physical Injury process.

PROCESS Make Cover Decisions for Mental Injury Caused by Physical Injury

NOTE **What if it's a request for cover for a work related mental injury?**
Refer to Make Cover Decision for Work-Related Mental Injury Claims process.

PROCESS Make Cover Decisions for Work-Related Mental Injury Claims

NOTE **What if the request is for a sensitive claim and is in Assisted Recovery?**
Transition the claim to Partnered Recovery, refer to Transition Claim process.

PROCESS Transition Claim

NOTE **What if the request is for a sensitive claim and is in Partnered Recovery?**
Refer to Make Cover Decision for Mental Injury Caused by Sexual Abuse process.

PROCESS Make Cover Decision for Mental Injury Caused by Sexual Abuse

NOTE **What if the request is for an imminently terminal condition?**
Refer to Escalate Permanent Injury Compensation application for a rapidly deteriorating client process.

PROCESS Escalate Permanent Injury Compensation application for a rapidly deteriorating client

NOTE **What if this is for a Maternal Birth Injury that is actively managed by the MBI Supported Recovery team?**
Transfer the claim to the MBI Supported Recovery Team.

NOTE **What if this is for a Maternal Birth Injury claim in Actioned cases or any other Recovery Teams?**
Transfer the claim to the MBI queue.

NOTE **What if the request is for cover for a hernia and you are a Treatment and Support Assessor?**
- Add a general task with the description: Assess additional diagnosis - 'Insert hernia type'
- Change the task priority to 'high'.
- Transfer the task to the Registration - Low Complex Dunedin queue.

d Ensure that you've read and understood the Timeframes to Determine Cover Policy below.

We must issue an extension decision advising the client of this before the current time frame expires. For more information please refer to the Complicated claim and Non-complicated claim Business Rules.

Timeframes to determine cover Policy

- Complicated claim definition
- Non-complicated claim definition
- Identify Claims for Rapidly Deteriorating Clients

2.0 Determine cover decision

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner, Treatment and Support Assessor

a Determine if an additional injury or change of diagnosis can be covered based on the information available by using the Add or change diagnosis decision traffic light tool.

- TOOL - Add or change diagnosis decision traffic light

NOTE **What if there is enough information available to make a decision?**
In Eos add the additional diagnosis into the Medical tab and set the Outcome Status to 'Accept or Decline', refer to the Add an Injury Code system steps below.
Go to step 3.0a Issue Recovery Decision and continue with the process.

- Add an Injury Code

NOTE **What if there is not enough information available to make a decision?**
In Eos add the additional diagnosis into the Medical tab and set Outcome Status to 'Investigating'.
Go to step 2.0c in Extend Cover Decision Timeframe process to create and send the CVR30 Time Extension – advise – claimant decision letter, and once completed return to this process and continue.
PROCESS Extend Cover Decision Timeframe

- CVR30 Time Extension - advise - claimant
- Add an Injury Code

NOTE **What if you are outside the 21 day timeframe to determine a cover decision and requires ongoing assessing?**
If ACC fails to meet the agreed timeframes on a cover decision, a client is deemed to have cover for their injury. Refer to Deemed Cover Decisions When Timeframes Not Met Policy.

Ensure you take the following steps :
1. contact the client to advise them that they have deemed cover for the diagnosis
2. in Salesforce add a contact to document your rationale for the decision (in Eos if you are a Cover Assessor or Lodgment Administrator)
3. generate CVR75 Deemed cover - client letter
4. send the letter via the client's preferred method of communication
5. in Salesforce, in the Recovery Plan, update Life Area: Health: Diagnosis [name] - accepted
6. continue with the process.

PROCESS Deemed Cover Decisions When Timeframes Not Met Policy

- CVR75 Deemed Cover - client letter

b In Eos, create the 'NGCM - Cover decision required' task.

NOTE **What if you are a recovery team member?**
1. edit the description of the task with the diagnosis (name of diagnosis) and the date the cover decision is due.
2.change the target date of the task to one month before the due date.
3. change the priority to 'High'.

NOTE **What if you are a Cover Assessor?**
Edit the task that you received with the following:
1.additional diagnosis name.
2.decision due on date.
3.set the priority to 'High'.
4.set the target date to 3 working days before the decision due date.

c Determine if you need to request medical notes. Refer to the Request Clinical Records process for guidance.

NOTE **What are examples of additional medical notes?**
Lodgment notes, imaging, specialist records, etc.
PROCESS Request Clinical Records

NOTE **What if you cannot make a decision in the legislative timeframe?**
You have to make a decision with the information available, you can continue to assess or investigate as more information is received.

NOTE **How to request information from NZ immigration (Customs/PAX)**
When requesting information around a client's international movements from NZ immigration - movementchecks@customs.govt.nz - Also referred to as Customs or PAX movements - Please include a copy of the ACC45 with the request and wording request:
"I am currently considering a request for ACC cover and I need to confirm (x travel dates) for the following person: (client's details).

I've attached a copy of the ACC45 form for this claim, in which the client authorises ACC to collect information to determine what support ACC can provide.

This request is in line with Principle 2(2)(c) and disclosure is in line with Principle 11(1)(c) of the Privacy Act 2020."

NOTE **What if the claim is in Enabled Recovery?**
Transition the claim to Assisted Recovery, refer to Transition Claim process below.
PROCESS Transition Claim

d In Salesforce, in the Recovery Plan update Life Area: Health: Request for new diagnosis [name of diagnosis] received through [source] on [the date received]. Cover decision is due on [date].

NOTE **What if you are a Cover Assessor?**
This is not required as you don't have access to Salesforce.

e Review the clinical notes once received for any additional information needed to make a decision.

f Determine if cover for the additional diagnosis can be accepted or declined using the Add or change diagnosis decision traffic light tool.

- TOOL - Add or change diagnosis decision traffic light
- Complex Regional Pain Syndrome
- Guideline for accepting cover for concussion

NOTE **What if the additional diagnosis is for a hernia?**
Contact the client and complete the 'ACC6261 Cover Assessment - Initial Call Summary - Hernia' document.
PROCESS Cover Criteria for Abdominal Wall Hernia Policy

- ACC6261 Cover Assessment – Initial Call Summary - Hernia

NOTE **What if you are unsure whether you can accept or decline the additional diagnosis or change in diagnosis?**
Seek guidance via the Seek Internal Guidance process
PROCESS Seek Internal Guidance

NOTE **What if you fail to make a decision in the legislative timeframes?**
If ACC fails to meet the agreed timeframes on a cover decision, a client is deemed to have cover for their injury. Refer to Deemed Cover Decisions When Timeframes Not Met Policy.

For non-complicated claims - if approaching the 4 month timeframe:
• You must issue a decision with the information you have.

For complicated claims - if approaching the 4 month timeframe:
• You will need to request a further timeframe extension from the client, using the CVR31 Time Extension request - client letter.
• Go to step 2.1a in Extend Cover Decision Timeframe process and follow all the steps.
• Once completed return to this process and continue.
Note that prior to the end of the additional 5 months you must make a decision with the information you have.
PROCESS Extend Cover Decision Timeframe

- Deemed cover decisions when timeframes not met Policy
- CVR31 Time Extension - request - claimant

3.0 Issue cover decision

Cover Assessor, Recovery Assistant, Recovery Coordinator, Recovery Partner, Treatment and Support Assessor

a In Eos, in the Medical tab update the diagnosis status to 'Approve or Decline' and then generate the appropriate decision letter.

- CVR70 Cover approve - add injury - claimant
- CVR999 Cover decline decision - client

NOTE **What if the claim is for a complex mental injury?**
Generate the appropriate decision letter.
• MIS12 Approve Mental Injury - Client.
• CVR999 Cover Decline decision – client.
• SCU999 SCU Cover decision - PO - client.

- MIS12 Approve mental injury claim - client
- CVR999 Cover decline decision - client

SCU999 SCU Cover decision - PO - client

NOTE **What if the claim is for a Work Related Personal injury (WRPI)?**
This is a new cover decision for the liable employer who needs to be notified with review rights (Section 64(2)). An additional letter CVR48 Claim approve - work injury - Employer must be generated.

CVR48 Claim approve - work injury - employer

b In Salesforce, in the Recovery Plan, update Life Area: Health : Diagnosis [name] - accepted or declined.

NOTE **What if you are a Cover Assessor?**
This is not required as you don't have access to Salesforce.

c In Eos, close the 'NGCM - Cover Decision Required' task.

NOTE **What if you are a Cover Assessor?**
In Eos, close the appropriate task you have been working on.

d Go to Issue Recovery Decision process for guidance on recording and communicating the decision with the client.

PROCESS **Issue Recovery Decision**
Recovery Assistant, Recovery Coordinator, Recovery Partner

Claim Lodgement v14.0

Summary

Objective
Claims can be submitted on any of the ACC-approved ACC45 injury claim form versions, electronic methods or the Accident Insurance Treatment Certificate (AITC).

Owner [Out of Scope]

Expert

Procedure

1.0 Lodging a claim

a When a claim is lodged, it is important to note that:
- acceptance for lodgement does not mean a claim has been accepted for cover
- the date of lodgement determines when the 'clock starts ticking' for the purposes of determining the correct insurer, cover and payment of statutory entitlements
- mandatory information is required for each claim.

b For more details, see the related business rules below.

- Claim lodged using claim form
- Registration of a claim
- ACC issued claim number
- Claim number assignment
- Client consent for claim lodgement
- Treatment provider lodging on behalf of a client
- Claim lodgement: accredited employer claim
- Claim lodgement: non accredited employer claims

2.0 Client & claim records

a When a claim is lodged the rules about client records and claim records listed below must be followed.

- Client record
- Unique claim records
- One claim per claim record
- One client per client record
- One client per claim
- Duplicate clients
- Add employer when employer can be identified
- Add a default employer when the employer cannot be identified
- Matching client record to a claim record when no NHI number – system and manual lodgement
- Matching client record to a claim record when NHI number – manual lodgement
- Matching client record to a claim record when verified NHI number – system lodgement
- Matching client record to a claim record when non-verified NHI number – system lodgement

3.0 Claim lodgement methods

a The rules listed below define the methods of claim lodgement acceptable to ACC.

- Claim lodgement methods
- Claim lodgement method types
- Client lodgement methods
- Authorised representative lodgement methods
- One method of lodgement
- Treatment provider lodgement methods

- Accident Information Definition

b For all non-work injuries, or work injuries received after 1 July 2000 use:
• the ACC45 ACC injury claim form (ACC45).

For work injuries received between 1 July 1999 and 30 June 2000 use:
• an ACC45 or AITC.

4.0 Collecting claim information at registration

- Snapshot of registration
- Storage of claim information
- Claim information for a claim
- Inbound documentation

5.0 Claim types

a A claim type is used to determine the allocation of a claim for a cover decision and claim management (if accepted).

- Assigning a claim type
- Mandatory claim information for claim type identification
- Who can assign a claim type

b Claim types are defined using the following rules.

- Complex claim type definition
- Non-complex claim type definition
- Simple dental claim type definition
- Assigning dental complex claim type
- Fatal complex claim type definition
- Hearing loss complex claim type definition
- Mental injury complex claim type definition
- Sensitive complex claim type definition
- Treatment injury complex claim type definition
- Work-related gradual process complex claim type definition
- Work-related mental injury complex claim type definition
- Claim type to be assigned if multiple complex claim types identified

Rule Name	**Client lodgement methods**
Statement	A **client** may lodge a **claim** only if it's via one of the following **claim lodgement methods**: • **email.** • **mail.** • **fax.** • **in person.**
Motivation	This ensures a Client cannot lodge a claim via a Practice Management System, or Healthlink, as these methods are only for Treatment Providers.

Rule Name	**Authorised representative lodgement methods**
Statement	An **authorised representative** of a **client** may lodge a **claim** only if via one of the following **claim lodgement methods:** • **email.** • **mail.** • **fax.** • **in person.**
Motivation	To provide other people the means to lodge a claim on behalf of a client

Rule Name	**Claim lodged using claim form**
Statement	A **claim** must be lodged using a **claim form** if the **Accident Compensation Corporation** does not already hold the **claim information**.

Motivation	This ensures a claim is lodged in a documented form when ACC does not already hold claim information. This rule also means that in the case when ACC does hold claim information a claim form is not required for the claim to be registered.

Business Term	**claim information**
Description	any fact or knowledge about a claim
Synonyms	