Complete this form to request and validate ongoing treatment of behalf of a client. When you’ve finished, please email this form to [ACC32@acc.co.nz](mailto:ACC32@acc.co.nz).

Please indicate:  Trigger number  Treatment beyond 8 weeks only.

|  |  |
| --- | --- |
| 1. Client details | |
| ACC45 number or ACC claim number: | |
| Client name: | Occupation: |
| Postal address: | |
| Date of injury: | Date of birth: |

|  |
| --- |
| 2. History, examination and diagnosis |
| What was the initial diagnosis? |
| What is the current diagnosis and read codes? |
| Please provide your rationale for requesting continued treatments under the Urgent Care contract: |
| Number of treatments given to date? |
| Please attach copy of relevant clinical records. |

|  |  |
| --- | --- |
| 3. Treatment plan (What do you need approval for?) | |
| **Expected duration of treatment post 8 weeks:** | **Number of treatments requested:** |
| weeks | Simple follow up:  Complex follow up:  Casts (please specify service code): |
| Comments: | |

|  |  |  |
| --- | --- | --- |
| 4. Provider details | | |
| Treating practitioner name:  Address: | Or provider stamp here: | |
| Provider type: | ACC Provider ID: | |
| ACC Vendor ID: | Phone number: | |
| Provider’s signature: | | Date: |

When we collect, use and store information, we comply with the Privacy Act 1993 and the Health Information Privacy Code 1994. For further details see ACC’s privacy policy, available at www.acc.co.nz. We use the information collected on this form to fulfil the requirements of the Accident Compensation Act 2001.