



# Details of Aids, Appliances Modifications

This form is used by the Approved Rehabilitation Provider or medical practitioner to detail aids or appliances recommended for the employee. It should be accompanied by a report supporting the recommendation. It should be forwarded to the claims manager at Comcare, who has the authority to approve/not approve the costs. No costs should be incurred until the claims manager has issued an approval.

Claim number	Title	Family name	Given name(s)

Address Residential

Address Postal

Phone number	Home	Work

Employer

Details of required aid or appliance

Is the aid or appliance a replacement of one previously purchased by Comcare	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Reason aid or appliance required

Length of time aid or appliance is required

Provider of aid or appliance

Recommendation by Rehabilitation Provider or Doctor	Signature	Date
Recommended by		

## Comcare Use Only

Payment of the expenses listed above, is hereby approved/not approved under Section 16/39 of the SRC Act 1988

on this day Date \_\_\_\_\_

Signature \_\_\_\_\_

Claims Manager \_\_\_\_\_