Australian Government

Comcare

CLAIM FOR AIDS OR APPLIANCES EXCLUDING HEARING AIDS

Please complete this form if you want to claim for aids or appliances under the *Safety, Rehabilitation and Compensation Act 1988* (SRC Act).

DISCLOSING AND SHARING OF INFORMATION

Comcare is authorised by the SRC Act to collect personal information relevant to an injured worker's claim for the purposes of managing the compensation claim and for the management of the injured worker's rehabilitation and the discharge of other functions and use of other powers under the SRC Act.

For those purposes, Comcare may need to collect from and use and disclose your personal information to the following parties:

- your employer at the date of your injury, your current employer and any subsequent employer
- your superannuation fund manager or trustee
- any health professional, hospitals, other health institutions, or service providers related to your claim
- your case manager
- your rehabilitation provider
- vocational and functional assessor
- employment agencies
- legal advisors and law enforcement authorities
- personnel engaged by Comcare to conduct research related activities
- the Safety, Rehabilitation and Compensation Commission
- Comcare fraud investigators
- inspectors appointed under section 156 of the *Work Health and Safety Act 2011*
- any relevant third party (or insurer) considered by Comcare to have contributed to the injury, illness or impairment
- any other person assisting Comcare in the performance of its functions or exercise of its powers
- any other entity where there is a legal obligation to do so (for example, but not limited to, responding to the direction of a Court to produce documentation)

PRIVACY INFORMATION

Your privacy is important to us. For information about how we handle your personal information, please visit www.comcare.gov.au/privacy or contact us on 1300 366 979 and request a copy of our Privacy Policy.

PART A: EMPLOYEE'S DETAILS

Comcare claim reference number (if known)	/
Surname	
Given name(s)	
Date of birth	Day Month Year
Residential address	

Postal address

Date of injury — Day Month Year

Accepted condition

Details of aid or appliance claimed for

Is the aid or appliance a replacement of one previously approved by Comcare? ☐ Yes ☐ No

INJURED WORKER'S DECLARATION

I declare that:

- the information I have supplied on this form and any other attachment is true and accurate
- I am aware that the making of a false or misleading claim or false or misleading statement in support of that claim is punishable by law under the *Criminal Code Act 1995* and, in that event, I may be liable for prosecution
- I am aware that any monies paid by Comcare as a result of a false or misleading statement or claim will be recovered.

Signature — Date / /

PART B: TREATING PRACTITIONER TO COMPLETE

Reason aid or appliance is required

Length of time aid or appliance is required

TREATING PRACTITIONER'S DETAILS

Name

Address

Phone ( ) — Fax ( )

Qualifications

Specialty

Provider number

Signature — Date / /