

**Instructions**

This form may be completed for surgery requests made **more than 90 days** after the client’s transport accident. A request is not required for surgery that is clinically indicated, transport accident injury related and within the first 90 days of the accident date (or for clients with a [severe injury](https://www.tac.vic.gov.au/clients/how-we-can-help/treatments-and-services/policies/supporting/definition-of-severe-injury), the first 12 months).

To avoid delays, complete in **full** and provide copies of all relevant diagnostic finding reports and other documents. Refer to the TAC’s policy on [Surgery and medical specialists](https://www.tac.vic.gov.au/clients/how-we-can-help/treatments-and-services/policies/surgery-and-medical-specialists).

Submit this form to [info@tac.vic.gov.au](mailto:info@tac.vic.gov.au) with the subject line ‘Surgery request for claim number \_\_\_\_\_\_\_’.

# Section 1

## TAC client details

|  |  |  |  |
| --- | --- | --- | --- |
| First name |  | Last name |  |

|  |  |  |  |
| --- | --- | --- | --- |
| TAC claim number |  | Date of birth | / / |

# Section 2

## SURGERY REQUESTED and clinical indication

Describe the surgery to be performed. Include recommended surgical treatment, body site, and body side.

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What are the clinical indications for this surgery? Please include the relationship between the surgery and your patient’s transport accident injuries?

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**If relevant,** please include any previous surgical or non- surgical interventions related to this transport accident injury and their outcome(s).

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| --- | --- | --- |
| Previous treatment | Date of surgery/intervention | Outcome |
|  | / / |  |
|  | / / |  |
|  | / / |  |
|  | / / |  |
|  | / / |  |

Please tick the anticipated hospital admission requirements associated with the surgery.

|  |  |
| --- | --- |
| Day procedure  Overnight stay  Multi-night stay Include number of nights: |  |

Please tick the anticipated rehabilitation or support services required after the surgery.

|  |
| --- |
| Physiotherapy  Occupational therapy  Nursing care  Personal care  Inpatient/Outpatient rehabilitation  Other(s) – please specify: |

What are the anticipated MBS item numbers?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| MBS item number/s | | | | | |
|  |  |  |  |  |  |

\* Approved surgeries, including related hospital and anaesthesia expenses will be paid for according to our fee schedule. Post-surgical rehabilitation requires a separate request. For a list of our rates, see [Medical services reimbursement rates](https://www.tac.vic.gov.au/clients/how-we-can-help/treatments-and-services/payment-rates/fee-schedule/medical-practitioners). For the multiple operation rule, [access this page](https://www.tac.vic.gov.au/clients/how-we-can-help/treatments-and-services/payment-rates/fee-schedule/medical-practitioners/reimbursement-rates-for-medical-service#:~:text=For%20multiple%20dislocations%20or%20fractures%20where%20the%20second%20or%20subsequent,75%25%20of%20the%20TAC%20fee.).

Please provide the details of anticipated prostheses.

|  |  |  |
| --- | --- | --- |
| Product name | Device company name | Planned placement location(s) |
|  |  |  |
|  |  |  |
|  |  |  |

**For gap-permitted or unlisted prostheses only**, please include details and clinical justification.

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# Section 3

## dIAGNOSTIC REPORTS & CORRESPONDENCE

To assist approval process, please provide copies of **relevant** diagnostic reports and other documents (e.g. Letters to GP). Tick all document types attached.

|  |
| --- |
| X-ray  CT  MRI  Ultrasound  Nerve conduction studies  Pain diary |

|  |  |
| --- | --- |
| Other reports or letters to other treaters: |  |

**If relevant**, provide clinical comment about report(s):

|  |  |
| --- | --- |
|  |  |

Note that if relevant reports/documents are not submitted with this request, the TAC may not have the information required to make a decision and delays may occur.

# SECTION 4

## PROVIDER DETAILS

Acknowledgement

I have discussed this treatment plan with my patient and I agree to discuss this plan with members of the TAC Clinical Panel as required. I understand that I can only bill the TAC for treatment that is directly related to my patient’s transport accident and that I am not able to bill for the return of the information requested in this form.

|  |  |
| --- | --- |
| Provider name, Medicare provider number, address,  email and phone number  (Type details or insert image of  practice stamp) |  |

|  |  |
| --- | --- |
| Signature  Insert image (jpg/png) of signature.  (Or print, sign and scan the form) |  |

Icon

Description automatically generated

|  |  |
| --- | --- |
| Date | / / |

# SECTION 5

Assessment

This request will be reviewed by a claims representative from the TAC and, in some circumstances, a member of the TAC’s Clinical Panel. The TAC will advise you and your patient of the outcome of this request in writing.

Privacy

The TAC will retain the information provided and may use or disclose it to make further inquiries to assist in the ongoing management of the claim or any claim for common law damages. The TAC may also be required by law   
to disclose this information. Without this information, the TAC may be unable to determine entitlements or assess whether the treatment is reasonable and may not be able to approve further benefits and treatment. If you require further information about our privacy policy, please call the TAC on 1300 654 329 or visit our website at [www.tac.vic.gov.au](http://www.tac.vic.gov.au)