ACC 2152

Treatment Injury Claim

Treatment Providers use this form in addition to the ACC45 or the ACC42 (dental) when lodging a claim for injuries which occur in the context of treatment.

PREVENTION. CARE. RECOVERY.
Te Kaporeihana Āwhina Hunga Whara

PART A: PATIENT DETAILS

Patient's family name: [Claimant surname]	Patient's first name(s): [Claimant first name]	
Patient's date of birth: [Claimant DOB]	Patient's NHI number: [Claimant NHI number]	ACC45/ACC42 claim number:

PART B: TREATMENT INJURY DETAILS

List the injury(ies) caused by the treatment:	Diagnosis coding: ☐ ICD10 ☐ READ CODE ☐ And reason (Dental) Diagnosis code(s) (if available):
List the signs and symptoms of the injury:	
Date which the patient first sought or received treatment for the injury:	
How does the injury affect the patient's daily activities?	

PART C: TREATMENT (CLAIMED TO HAVE CAUSED THE INJURY)

What treatment gave rise to the injury? (If the claimed injury resulted from failure to treat, please note.)	Diagnosis coding: ☐ ICD10 ☐ READ CODE ☐ And reason (Dental) Diagnosis code(s) (if available):
Describe the events or circumstances which led to the injury. Include details of any medications and dates prescribed. (Please attach additional information if required.)	

Where was treatment provided?

☐ Specialist rooms	☐ GP/medical centre	☐ Operating theatre	☐ Emergency department	☐ Ward/special unit
☐ Pharmacy	☐ Community clinic	☐ Hospital outpatient clinic	☐ Rest home/aged care	☐ Home
☐ Laboratory	☐ Radiology	☐ Other diagnostic/treatment area	☐ Other – please specify:	

Name of the facility (if relevant):

Outline the condition(s) being treated (with dates):	Diagnosis coding: ☐ ICD10 ☐ READ CODE ☐ And reason (Dental) Diagnosis code(s) (if available):

Outline all underlying health conditions and other relevant factors/treatment. (If the injury is a worsening of an existing condition, please note.)

Name and occupation of the health professional(s) who provided or directed treatment. (ACC may need to contact these people for more information.)

Other information which may be relevant to this claim. (If there are related ACC claims, please note.)

PART D: TREATMENT PROVIDER DECLARATION

To be signed by the health professional completing this claim form.

I certify that the information provided is accurate, to the best of my knowledge.

ACC Provider number:

Treatment provider name:	Or Treatment provider stamp:
Occupation:	
Address:	

Treatment provider signature: **Date:**

Attach available relevant documents, for example copies of clinical records such as discharge summaries, clinic letters, operative report, radiology report, incident form. Don't delay lodging this claim if these documents are not immediately available.

Lodging a treatment injury claim

- The ACC45 or ACC42 form can be lodged electronically or manually.
- Please email, fax or post the ACC2152 form and clinical notes to: ACC Treatment Injury Centre, PO Box 430, Dunedin 9054, Fax (04) 560 5361, email TIClaims@acc.co.nz
- Send your invoice to your ACC Service Centre (check www.acc.co.nz for contact and invoicing details)

FOR HOSPITAL ADMINISTRATION USE ONLY

The information collected on this form will only be used to fulfil the requirements of the Accident Compensation Act 2001. In the collection, use and storage of information, ACC will at all times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code 1994.