

SA Health General Practitioner Fee for Service Motor Vehicle Accident Fee for Service Claims Declined for Compensation

As per SARMFA 3.25 Payment for Individuals involved in a motor vehicle accident that was initially assessed as being eligible for compensation but is subsequently declined eligibility

In recognition of the fact that the agreement between SA Health and the Motor Accident Commission does not extend to medical practitioners operating under fee-for-service arrangements, CHSALHN will underwrite any compensable motor vehicle accident episode of care that is deemed unclaimable or is rejected by the insurer.

The health service will approve payment of any fee-for-service inpatient claim relating to that episode of care, subject to verification through a copy of the rejection letter from Allianz, or in a single vehicle accident through the notes made at the time by the medical practitioner or the South Australian Ambulance Service.

Payment will not be made for any claims:

- where 'fault' cannot be determined (eg a multiple vehicle accident where the matter should be referred to Allianz to determine who was the driver at fault)
- if patient chooses to voluntarily waive their right to compensation
- if a patient fails to submit a claim to Allianz where compensation would be claimable

A claim form needs to be completed and the supporting documentation provided whenever a claim is made.

Claimant Details

Hospital _____
Medical Practitioner Name _____
Medical Clinic _____
Address _____

Claimant Declaration

FFS claim attached is for a patient admitted as a Compensable Motor Vehicle Accident, however it is requested the patient be treated as a Public patient due to:

- A. MVA Claim Rejected by Allianz (letter from Allianz Attached)
- B. Compensation not claimable for patient due to:
- Patient was Driver at Fault
 - Patient was Driver in Single Vehicle Accident
 - Other (please specify) _____

(Office Use Only)

Above reason Confirmed Yes No If No, reason _____

Authorised for payment on behalf of Country Health SA Local Health Network

Signature _____

Name _____ Date _____

Position held _____

DETAILS OF MVA – Rejected/Unclaimable Fee for Service Claim

Date: _____ **Medical Practitioner:** _____ **Hospital:** _____

Signature _____

| DATE | MRN / DOB | PATIENT NAME | AH Call Back | TIME IN | TIME OUT | Item Number / CMB Code | DESCRIPTION OF SERVICES | OFFICE USE ONLY | |
|------------------------|-----------|--------------|-----------------|---------|-------------|------------------------------|----------------------------|--------------------|---------------|
| | | | | | | | | No. | FFS Amount |
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| FFS ADHOC CODE: | | | MACREJ | | | | | | |
| TOTAL | | | | | | | | | |