MAIC Motor Accident Insurance Commission

Provider Treatment Plan – Physical

☐ Initial plan ☐ Subsequent plan Treatment plan number Date / / DD/MM/YYYY

MAIC supports the Clinical Framework for the Delivery of Health Services. Visit **maic.qld.gov.au** to access the framework and for a guide to completing treatment plans. Funding of proposed treatment is not guaranteed without prior approval by the CTP insurer.

Compulsory Third Party (CTP) insurer details

CTP Insurer

☐ Allianz ☐ Nominal Defendant ☐ QBE ☐ RACQ ☐ Suncorp

CTP claim number

Injured person

Name

Date of accident / / DD/MM/YYYY

Date of initial consultation / / DD/MM/YYYY

Number of sessions to date

Number of unpaid previous sessions

Occupation

Pre-accident work hours/week

Current work hours/week

Current work duties ☐ Normal duties ☐ Modified duties ☐ Not applicable

Referrer

Referrer telephone ( )

Reason for referral

Current assessment

Details of any relevant pre-existing conditions or treatment prior to the motor vehicle accident

Current subjective/objective assessment

Provisional diagnosis

Functional ability (include test scores from relevant outcome measures)

Factors affecting recovery (include risk factors that may pose barriers to return to social and occupational roles)

Treatment progress to date (if applicable)

Target problem	Treatment goals (incl. function goals)	Treatment method	Progress to goal attainment

Proposed treatment

Details of treatment proposed (treatment goals should be SMART)

Target problem	Treatment goals (incl. function goals)	Treatment method	Measures to be used	Review date
				/ /
				/ /
				/ /

Self-management strategies recommended

Proposed treatment

_____ sessions over _____ weeks at $ _____ per session.

Other details of proposed treatment (if applicable)

Provider name

Qualifications

Practice name

AHPRA registration number (if applicable)

Practice address (include unit number (if applicable), street number and street name)

	Street type	
Suburb/town	State	Postcode

Email address

Telephone ( )

Signature

Date / /
DD/MM/YYYY

CTP insurer contact details

Please forward the completed treatment plan and copies of medical referrals, correspondence and outcome measures to the relevant CTP insurer.

Allianz: qldctpclaims@allianz.com.au **Nominal Defendant:** nd@maic.qld.gov.au au **QBE:** myctpclaim@qbe.com
RACQ: ctpclaims@racq.com.au **Suncorp:** qldctpclaims@suncorp.com.au

Insurer use only

Funding approved ☐ Yes ☐ No† ☐ Partial†

Date / /
DD/MM/YYYY

Details/comments

Insurer representative name

Signature

† *Insurer will provide written explanation if plan is partially/not approved*