



Toll Group
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www.tollgroup.com

Toll Holdings Limited
ABN 25 006 592 089

Toll Group (Self-Insurer) Request for Reimbursement

Claimants Name:

Claim Number:

Important Information on your Reimbursement Request:

- All Invoices/Receipts **MUST** be submitted with this form
- **EFTPOS Receipts alone cannot be accepted**
- All Reimbursements are paid in accordance with Section 219(6)(a)(b) of the *Workers' Compensation and Rehabilitation Act 2003*, the insurer is not liable for travel expenses incurred by the worker, if
 - Travelling a distance of less than 20km each way, or
 - If treatment or rehabilitation for the injury was reasonably available to the worker nearer than the place which the worker has travelled to see the treatment or rehabilitation
- Medical Expenses – The medication **MUST** be listed on your Workers Compensation Certificate of Capacity/Workers Compensation Medical Certificate

Medical Treatment Reimbursement

Date	Name of Procedure	Name of Treating Doctor	Invoice Total	Amount Requested for Reimbursement
			\$	\$
			\$	\$
			\$	\$
			\$	\$
			\$	\$
			\$	\$
TOTAL			\$	\$

Prescription/Prosthetic Reimbursement

Date	Name of Prescription or Prosthetic	Name of Treating Doctor	Invoice Total	Amount Requested for Reimbursement
			\$	\$
			\$	\$
			\$	\$
			\$	\$
			\$	\$
			\$	\$
TOTAL			\$	\$

Travel Reimbursement
Private Vehicle

Date	Address From	Address To	1.Purpose of travel 2. Amount of kilometres travelled

Public Transport

Date	From	To	Type of Transport	Total	Purpose
				\$	
				\$	
				\$	
				\$	
TOTAL				\$	

Rideshare/Taxi

Date	From	To	Type of Transport	Total	Purpose
				\$	
				\$	
				\$	
				\$	
TOTAL				\$	

Public Car Parking

Date	Name of Car Park	Total	Purpose
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Internal

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		\$	
		\$	
		\$	
		\$	
TOTAL		\$	

- *I acknowledge that is an offence against the Workers' Compensation and Rehabilitation Act 2003 to make a statement that is false and misleading*
- *If I have claimed in full or in part amounts though my private health fund or Medicare, I am ONLY requesting reimbursement for the out of pocket amount*

Name:

Signature: _____

Date: _____



Internal

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