**Employer Claims Excess - Advice of Payments**

Please complete this form to advise us of the payments you have made toward your employer excess.
The employer excess equals payment of the:

* reasonable costs of medical and like services up to a maximum amount of $735.00, and
* first 10 days of a worker's incapacity based on the days the worker would have worked but for the injury.

WORKCOVER AGENT: CLAIM NUMBER:

EMPLOYER NAME: WORKER’S NAME:

**A. Weekly Payments**

|  |  |  |  |
| --- | --- | --- | --- |
| NUMBER OF DAYS PAID:(maximum of 10 days of incapacity)  |   | AMOUNT PAID: | $  |
| SPECIFY DATES |
| \_\_/\_\_/\_\_ | \_\_/\_\_/\_\_ | \_\_/\_\_/\_\_ | \_\_/\_\_/\_\_ | \_\_/\_\_/\_\_  |
| \_\_/\_\_/\_\_ | \_\_/\_\_/\_\_ | \_\_/\_\_/\_\_ | \_\_/\_\_/\_\_ | \_\_/\_\_/\_\_ |

**B. Medical and Like Services**

List details of all medical and like services which you have paid:

|  |  |
| --- | --- |
| ACCOUNT DETAILS (NAME OF PROVIDER): | AMOUNTS PAID: |
|   |   |
|   |   |
|   |   |
|   |   |
|   |   |
|  |  |
|  |  |
|  |  |
|  |  |
| **Total medical and like services payments**(maximum of $735.00 from 01.07.2020) | **$** |

A part payment of an account can be made to enable the excess to be met.

Please attach copies of all accounts for medical and like services indicating whether they are "Paid" or "Unpaid" by you.

Signature of Employer: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_