

Request for Income Compensation Reimbursement

Worker's name	Claim number
Employer's name	Date of injury
Employer's address	Postcode

Direct credit option – for reimbursement via direct credit to employer's bank account complete the following:

Bank account name		
BSB number	–	Account number
Employer's email address		

Code (see below)	Period (inclusive dates)		Weeks	Days	Hours	Weekly rate	Amount
	From	To					
						\$	\$
						\$	\$
						\$	\$
						\$	\$
						\$	\$
						\$	\$
						\$	\$
						\$	\$
						\$	\$
TOTAL							\$

Codes T – Total Incapacity R – Restricted duties (Return to Work Program) SD – Step down rate (After 26 weeks rate of pay) T.L.V.D. – Time Lost Visiting Doctor Important 1. If compensation relates to time lost visiting doctor and is less than one day, show 'T.L.V.D.' against period and indicate hours lost each visit. 2. Ensure that medical certificates supporting periods of absence are submitted. (Payment cannot be processed without certification). 3. Specify actual dates. Do not use 'week ending' or 'retrospective'.	Office use only
Employer's signature X	Date / /

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