Australian Government
Department of Health

Hearing Services Program
Request for Reconsideration of Reviewable Decision

Purpose

To request a reconsideration of a decision.

People who are affected by certain decisions made under the *Hearing Services Administration Act 1997* are able to apply for those decisions to be reconsidered. For information on decisions able to be reconsidered, see the Reconsideration and Appeals fact sheet on the web site at

www.hearingservices.gov.au

What we will do

An officer of the Department of Health who did not make the original decision will review your application. They will

- review the decision, taking into account any evidence you have provided
- uphold, vary or revoke the original decision and
- advise you of the outcome of the review in writing.

Privacy Notice

Any personal information about you collected by the Department of Health (the Department) for the Australian Government Hearing Services Program (the program) will be managed in accordance with the *Privacy Act 1988*.

More information can be found at the Privacy and Security page of the Department's website.

When you provide information to the Department for the purposes of the program, please be aware that the Department may disclose this information to other government agencies including Centrelink, Medicare, the Department of Veterans' Affairs, the Department of Defence or the National Disability Insurance Agency.

Your information will only be used for the following purposes

- checking your eligibility for the program
- enabling the effective administration and accountability of the program, and
- analysis for the purpose of improving service delivery and policy.

When to submit

You must request a review within 28 days of the date of the decision. You may ask for an extension, please explain why you needed the extra time.

Instructions

- Complete all applicable fields in the form
- Make sure you have explained in Section C why the original decision is incorrect and ensure that you have signed the declaration at Section D
- Attach any additional information to this form and
- Send the form and all supporting information to

  Hearing Services Program
  MDP 113
  GPO Box 9848
  Canberra ACT 2601

  or

  Email your completed form to hearing@health.gov.au**.** Please include 'Reconsideration' in the message subject.

Section A – Applicant details

Title* First name* (*Mandatory field)

Surname*

Postal address*

State* Postcode*

Contact phone*

Email

If you are a client please provide

Eligibility Information

Date of Birth

/ /

Please complete if you are a service provider

Provider Number Site Id

Trading Name

Please complete if you are a Qualified Practitioner

QP Number

Name and position of person authorised to act on behalf of the body corporate or partnership

Section B – Decision for review

What is the decision you want the department to reconsider, noting that not all decisions can be reconsidered?

(See Reconsideration and Appeals fact sheet)

What was the date of the decision and who was the decision maker?*

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Section C - Additional Information

Are you submitting additional information with this form?

☐ No ☐ Yes, (Please attach)

Why do you believe the decision was incorrect?*

Explain why you do not agree with the decision or provide details of incorrect information the decision was based on.

Attach more pages, if required.

Section D - Declaration*

I declare that the information I have provided in this form is complete and correct.

I understand that giving false or misleading information is a serious offence.

Applicants Signature

Date

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