## Purpose

Use this form to ask the Hearing Services Program to reconsider (conduct an internal review of) a decision it has made.

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 [Complaints policy](https://www.health.gov.au/resources/publications/hearing-services-program-complaints-policy).

## What we will do

Your application will be reviewed by an officer of the Department of Health who did not make the original decision. 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*.

If information is provided via our website, additional privacy and security measures apply. More information on these measures 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 this time period to be extended and explain why you did not submit this form within that 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**

Scan and email to hearing@health.gov.au**,** ensuring that the word ‘Reconsideration’ is included in the message heading.

## 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

 / /

If you are a service provider please provide:

Provider Number Site Id

Trading Name

If you are a Qualified Practitioner please provide:

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 program to reconsider, noting that not all decisions are able to be reconsidered?

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

 / /

## 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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