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| **Sensitive: Personal (when completed)** | | | | | | | | | | | | |
| **Your Name** |  | | | |  | **RTWS Name** | |  | | | |  |
| **Claim Number** |  | | | |  |  | |  | | | |  |
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| **Please note that in submitting this form to Gallagher Bassett, you declare that you have paid for the item/s listed and that the details of this form are true and correct and are related to your compensable disability. If insufficient evidence is received, we will not pay until relevant information is provided.** | | | | | | | | | | | | |
| **Item Description** | | | **For what injury (e.g. elbow)** | | | | **Type (please select one) Prescription or Over the Counter** | | | **Name of medical expert who prescribed or recommended the item** | | |
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