

# Acquittal Form - MASS 70

This form is used by supplier, prescriber and applicant for acquittal of aids supplied by MASS

**Medical Aids Subsidy Scheme (MASS) staff, in accordance with the MASS Privacy Statement, are committed to maintain strict confidentiality in all aspects of service delivery. You are assured that this information will remain confidential. Your information will not be divulged without your consent or unless required or authorised by law.**

MASS requires an acquittal process to be undertaken for all equipment over \$1,000, the acquittal is to ensure the applicant is provided with a quality product. The prescriber or delegate health professional, in consultation with the applicant, is required to indicate if the product is satisfactory for the applicant as prescribed and ordered by MASS to allow the supplier to be paid by MASS. **This process must occur within three weeks of supply of the aid.**

**Section A – Supplier to complete at time of delivery of the aid**

Client's name:		DOB:
Company:	Company representative name:	
Description of aid supplied:		
Date supplied:	MASS Purchase Order No:	
Method of delivery:		
Company representative signature:		Date:

**Section B – Prescriber/delegated health professional to complete after reviewing aid with the client**

Is the client comfortable using the aid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If 'No', please provide details:		
Does the aid provide the prescribed functional outcome?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If 'No', please provide details:		
Is the client satisfied with the aid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If 'No', please provide details:		
<input type="checkbox"/> I <b>am satisfied</b> that the aid provided is in accordance with the prescription and quote submitted to MASS. <input type="checkbox"/> I <b>am not satisfied</b> that the aid provided is in accordance with the prescription and quote submitted to MASS for the following reasons:		
Prescriber name:	Organisation:	
Phone:	Prescriber signature:	Date:

**Section C – Client/carer to complete after receiving aid, indicating that it is satisfactory**

Have you been provided advice: <input type="checkbox"/> in the use of the equipment <input type="checkbox"/> future maintenance & repair <input type="checkbox"/> a user manual			
If not provided, please give details:			
I acknowledge that the aid referred to in this form has been received.			
I <input type="checkbox"/> <b>am</b> / <input type="checkbox"/> <b>am not</b> satisfied with the aid.			
Signature:	Print name:	Date:	Phone:

**Post OR Fax completed forms to a MASS Service Centre**

**Brisbane:**  
 Medical Aids Subsidy Scheme  
 PO Box 281, Cannon Hill Qld 4170  
 Telephone: 3136 3636 Fax: 3136 3500  
 Email: mass184@health.qld.gov.au  
 Website: www.health.qld.gov.au/mass

**Townsville:**  
 Medical Aids Subsidy Scheme  
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