Australian Government
Department of Veterans' Affairs

Application for Refund or Payment of Privately Incurred Medical Expenses

NOTE: Please read the instructions on both sides before completing the form.

If your claim relates to the period when you were waiting for DVA eligibility to be granted, then you need to first claim reimbursement for all medical expenses through Medicare and/or your Private Health Insurance Fund, if this applies to you.

For all other claims, you should lodge your claim directly with your local DVA State Office, without seeking rebates.

File number

Particulars of Beneficiary who incurred the Expense

Surname	Given names	
Full postal address		Telephone number

Are you a member of a Private Health Insurance Fund?
(e.g. Medibank Private, Medical Benefit Association or Friendly Society) (Please tick) ☐ Yes ☐ No

Particulars of Applicant, where beneficiary is deceased or unable to apply

Surname	Given names	Relationship to Veteran
Full postal address		Telephone number

Details of Accounts and Receipts

(Original accounts and/or receipts must be attached for all items claimed)

Full name and address of provider, hospital or pharmacist	Provider number	Date of period of treatment	Has the account been paid? (Write Yes or No)	Total amount of account or receipt $	c	Refund received from Medicare or Health Fund $	c

If insufficient space, attach another signed form, or signed list.

Reasons for not using your Gold or White Card

You are required to attach a signed statement giving your reasons for not using your Gold or White Card. **DVA delegate will be unable to consider your application if reasons are not given.**

Applicant's Statement

I certify that the above statements are correct and I have received the goods and/or treatments listed.

I am aware that there are penalties for making false or misleading statements.

Applicant's signature / /

Your Authority

I authorise the doctors and hospitals who have treated me and are nominated in this form, to disclose any information related to the treatment listed above.

I am willing that a copy of this authorisation be accepted with the same authority as the original.

Applicant's signature / /

NOTE: Your claim can be finalised with a minimum of delay if you submit itemised accounts supported by the following evidence:

(1) Refunds from Medicare or Private Health Insurance Organisations

During the period that you are waiting for your eligibility to be granted, you should first seek refunds from Medicare and/or your Private Health Insurance Fund. Refund slips received from Medicare or your Private Medical or Health Insurance Fund must accompany this application. However, if you are unable to locate the appropriate refund slip, a detailed list from the organisation concerned must be attached to this application.

(2) Doctor's accounts

All doctors' accounts should show the date of each visit or consultation and the nature of the disability treated, and be certified by the attending doctor. The doctor's full name, address and provider number should be filled in on the front of this form.

(3) Hospital accounts

Dates of admission and discharge from hospital should be certified by a doctor. Accounts should also indicate the nature of the disability treated.

(4) Ambulance accounts

Should be accompanied by a certificate from the doctor who authorised the transport. The certificate should indicate the disability for which transport was required and the date of service.

(5) Physiotherapy accounts

Should be supported by a certificate from the doctor who prescribed treatment. Accounts should show the date and cost of each treatment and the date of service.

(6) Dental accounts

Should be supported by a certificate from the dentist indicating treatment provided and the cost of each treatment.

(7) Medicines (Refund may only be granted in respect of "prescribed medicines")

Copies of prescriptions should accompany all accounts. If a copy of a prescription is not available, an itemised receipt should be provided and certified by the dispensing pharmacist. This should include the name of the medicine, quantity dispensed, date and cost.

(8) Surgical aids and appliances–including spectacles

Should be supported by a certificate from the doctor who prescribed the aid, etc.

(9) Receipts

When claiming reimbursement **original receipts** must be produced. Only in exceptional circumstances will duplicate receipts be accepted. Veterans are advised to retain a copy of their receipts when they send in the original receipt.

For State Office Use Only

Claim No. ☐

Effective date: / /   Date advised: / /

Eligibility/Card Type: ☐ Gold ☐ White ☐ Orange

Checklist:

Is a statement of circumstances attached? ☐ No ☐ Yes

Has this veteran received a reimbursement for? ☐ No ☐ Yes

Treatment provided by this provider previously? ☐ No ☐ Yes

Is the veteran a member of a health fund? ☐ No ☐ Yes

Has any amount been claimed from Medicare or private health insurer? ☐ No ☐ Yes - how much? $

Comments by Medical Adviser (if required)

Recommendation by State Office:

Total amount to pay	Recommended by	Date	Extension No.
$		/ /	

Delegate Use Only

Reimburesement approved ☐ Reimburesement not approved ☐ Total amount approved $

Delegate's signature	Printed name	Extension No.	Date
			/ /