IMPORTANT

Australian Government
Department of Veterans' Affairs

Treatment Prior Financial Approval Request Form

Please send completed form and any supporting documentation to: health.approval@dva.gov.au

If you do not have access to email please post the form to: Health Approvals & Home Care team, Department of Veterans' Affairs, **GPO Box 9998, BRISBANE QLD 4001**.

This form is to be used for requesting prior financial approval to provide medical and/or allied health services to eligible veterans. Please note there are other prior approval request forms that relate to certain types of services, such as dental, optical, MRI and PET scans, chiropractic, physiotherapy and osteopathy. Please check the available forms to ensure you are using the most appropriate form.

Please attach clinical justification to this form. For further information and support please contact the **Provider Hotline Number: 1800 550 457**.

The provider is responsible for ensuring that the client is aware that their personal information is to be forwarded to DVA for determining and/or providing benefits under the relevant legislation. The information will be treated in a confidential manner. However, it may be used for clinical review, audit or management purposes or disclosed to the client's general practitioner.

Privacy notice

Your personal information is protected by law, including the *Privacy Act 1988*. Your personal information may be collected by DVA for the delivery of government programmes for war veterans, members of the Australian Defence Force, members of the Australian Federal Police and their dependants.
Read more: How DVA manages personal information.

Is this request part of assessing a compensation claim? No ☐ Yes ☐ ▶ Do not complete this form and proceed as detailed with TRN advice notice which can be provided by the DVA Client.

Date form completed / /

Name of person completing this form

Entitled Person Details

1: DVA file number

2: Surname

3: Given name(s)

4: Date of birth / /

5: Email address

☐ I have confirmed with the patient that they would like to receive the outcomes of the request via the email address provided above

6: Card type

Gold ☐

White ☐ ▶ Conditions/disability to be treated

▶ Contact DVA to check eligibility under the client's Accepted Disability(ies) on **1800 550 457**.

7: Does the entitled person live in a Residential Care Facility? No ☐ Yes ☐ ▶ Level of care

High ☐ Low ☐

Other ☐ ▶ Please specify

Details of Treatment or Service *cont...*

9: Please provide clinical justification for why the treatment is urgent. If known, please provide a proposed date of treatment

Please attach separate pages as necessary.

10: Details of treatment for which seeking prior financial authorisation, including *clinical justification*.

Please attach separate pages as necessary.

Service/Item Number Details *(if applicable)*

Please refer to the Repatriation Medical Fees Schedule (RMFS)

OR

Please refer to the applicable DVA Allied Health Schedule of Fees

http://www.dva.gov.au/providers/fee-schedules

Provider Details

11: Provider name

12: Provider number

13: Provider type (e.g. GP, Specialist, Dentist, Physiotherapist)

14: Address

POSTCODE

15: Telephone number [ ]

16: E-mail address

17: Item number(s) *(if applicable)*

18: Fee *(if other than RMFS fee)* $

Please include clinical justification for fee above the RMFS

Please attach separate pages as necessary.

Please ensure all information provided is clearly written, complete and correct as missing or incorrect information, including clinical justification for request, may delay the processing of your request.

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