Australian Government
Department of Veterans' Affairs

Prior Approval Request for Treatment of Alcohol and Other Substance Abuse (AOSA)

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

This form is to be used for requesting prior financial approval to provide treatment relating to substance abuse to eligible veterans.

This form must be completed by either a medical practitioner (for instance, a treating GP or psychiatrist), Open Arms, a hospital discharge planner or current treating psychologist. Requests for approval will not be accepted directly from the facility at which the treatment is being requested, or from the client who is seeking to receive the treatment.

DVA strongly encourages the use of contracted hospitals or providers in the first instance. Treatment at contracted facilities does not require prior approval, however you can complete this form to confirm whether the requested facility has contractual relationship with DVA, and whether the requested treatment is covered under that contract. Contracted faciliites can be found at the following links http://at-ease.dva.gov.au/node/656
http://www.dva.gov.au/providers/hospitals-and-day-procedure-centres

Treatment at non contracted facilities can be used in instances where there are no vacancies with contracted providers, or there is a compelling clinical need for an individual to utilise a non–contracted provider.

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.

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

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.

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 the benefits under 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 local Medical Officer.

The following information is required for DVA to consider prior approval requests for AOSA treatment service:

Referrer's Details

1. **Referrer name**
2. **Provider Number**
3. **Name of Referrer's practice/ facility**
4. **Contact Number** [ ]
5. **Email**

Details of Facility/Provider offering treatment

6. **Name of Provider or Facility**

7. **Contact person**

8. **Provider Number** (if applicable)

9. **Contact Number** [ ]

10. **Address of facility**

POSTCODE

11. **Email**

12. **ABN Number**

Entitled Persons Details

13. **DVA File Number**

14. **Surname**

15. **Given name(s)**

16. **Date of birth** / /

17. **Card type**

- [ ] Gold
- [ ] White – Relevant Conditions

The following information can be provided in a clinical letter if preferred.

18. **Previous & current alcohol & drug usage AND treatment history**

19. **Current mental health/medical diagnosis**

20. **Current prescribed medication(s)**

21. **Summary of impact of substance abuse on sociological factors (e.g. work, family, social life)**

22. Principal reason for admission to session/program

23. Justification for why a contracted provider is not being used
(Note: must be a compelling clinical reason)

24. Any other identified risks/issues?
(e.g. homelessness, violence)

☐ Homelessness ☐ Mental health ☐ Violence/abuse
☐ Suicidal thoughts/attempts ☐ Self harm

Provide additional information if necessary

As the referrer you must have contacted the facility and confirmed your client's ability to attend the program(s) that you are requesting below prior to submitting this form.

IMPORTANT: For every service requested please attach an outline of the program/treatment (e.g. a brochure or factsheet) and details of the staff providing the treatment and the qualifications of those staff. Requests without this information will not be able to be considered.

Services Requested

	Name of Provider/Program	*Length of Program (if applicable)*	*Planned start date (if applicable)*	*Planned end date (if applicable)*	*Total cost*	*Item number (if applicable)*
Assessment			/ /	/ /	$	
Withdrawal Management			/ /	/ /	$	
Residential Treatment			/ /	/ /	$	
Supported Accommodation			/ /	/ /	$	
Group Day Programs			/ /	/ /	$	
Post Discharge Follow up			/ /	/ /	$	
Counselling			/ /	/ /	$	
Case Management			/ /	/ /	$	

18. Additional relevant information
(e.g. details on other identified risk factors, Family Support)

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.