DISCHARGE ADVICE AND HOSPITAL CLAIM

Completing the form

To ensure prompt and accurate processing, complete all relevant sections of the form.

Prostheses Item Numbers: Please use the applicable billing codes as listed in the current Commonwealth Department of Health and Ageing Prostheses Schedule.

Separation Code: Include the relevant code from the following list:

A Discharged by hospital
B Discharged own risk
C Transferred to nursing home
D Transfer to psychiatric hospital
E Transfer to other hospital
F Death with autopsy
G Death without autopsy
H Transfer to other accommodation
I Type change separation
R Deceased
S Still an in-patient
W Nursing home
X Other hospital
Z Home

Patient Declaration: The patient must sign to certify services claimed have been received. If the patient is unable to sign, the patient's agent or Authorised Officer must sign.

Claimant Declaration: Must be signed by an Authorised Officer.

Claiming Payment

To claim payment, complete all relevant sections of the form and forward it, together with any supporting documentation, to the address shown.

The Discharge Advice and Hospital Claim form is supplied in duplicate. Please distribute as follows:

- **Original** (Departmental Copy) with any supporting documentation – send to Medicare Australia for claiming purposes (see address below).
- **Duplicate** (Hospital Copy) – claiming hospital to retain.

Manual Claiming

Mail your treatment vouchers to the appropriate address for processing, as follows:

Veterans' Affairs Processing
Department of Human Services
Providers in VIC, TAS, QLD:
GPO Box 9917, Melbourne VIC 3001

Providers in WA, ACT, NSW, NT, SA:
GPO Box 9917, Perth WA 6848

To discuss payment issues, please contact the Department of Human Services on 1800 550 017

Quote claim number for all enquiries.

Australian Government
Department of Veterans' Affairs

DISCHARGE ADVICE AND HOSPITAL CLAIM

Claim number

Staple attachments behind

The information sought on this form is required for provider verification and claim processing.
This information will be used by Department of Human Services to process the payment.
Please complete online and then print to sign and return

Name and address of hospital

Hospital provider number

DVA file number

Patient Surname

Given names

Date of birth
/ /

Dates of Service		No. of days	Item No.	Total Claimed
From	To			
/ /	/ /			$
/ /	/ /			$
/ /	/ /			$
/ /	/ /			$
/ /	/ /			$
/ /	/ /			$
/ /	/ /			$

Theatre Date	Procedure Item No.	Total Claimed
/ /		$
/ /		$
/ /		$
/ /		$

Miscellaneous	Date of Service
	/ /
	/ /
	/ /

Prosthesis Item No.	Date of Service	Total Claimed
	/ /	$
	/ /	$
	/ /	$
	/ /	$
	/ /	$

Principal ICD-10 Code

Is this account interim or final? Interim ☐ Final ☐
Is this a readmission within 7 days? Yes ☐ No ☐

Separation Code

Admitted for treatment of

Name of treating Doctor

Place to which discharged

Admission date
/ /

Discharge date
/ /

Your reference/Invoice No.

Patient Declaration

I certify that I have received the services described on this claim.
I am not entitled to claim third party or worker's compensation for these services.

Patient Signature / /

OR I certify the patient is unable to sign

Agent/Authorised Officer Signature / /

Declaration

I claim payment for the services specified above and certify that:

- to the best of my knowledge and belief all information given above is true
- all of the amounts claimed are for services rendered
- all of the amounts claimed are for services payable by the Department of Veterans' Affairs
- the patient required acute care for the whole of the period between the dates of service shown.

Authorised Officer / /

Australian Government
Department of Veterans' Affairs

Claim number

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Staple attachments behind

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Please complete online and then print to sign and return

Name and address of hospital	Hospital provider number
	DVA file number

Patient Surname	Given names	Date of birth
		/ /

Dates of Service From	Dates of Service To	No. of days	Item No.	Total Claimed
/ /	/ /			$
/ /	/ /			$
/ /	/ /			$
/ /	/ /			$
/ /	/ /			$
/ /	/ /			$
/ /	/ /			$

Theatre Date	Procedure Item No.	Total Claimed
/ /		$
/ /		$
/ /		$
/ /		$

Prosthesis Item No.	Date of Service	Total Claimed
	/ /	$
	/ /	$
	/ /	$
	/ /	$
	/ /	$

Miscellaneous	Date of Service
	/ /
	/ /
	/ /

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Authorised Officer / /