IMPORTANT

Australian Government
Department of Veterans' Affairs

Optical 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 optical services/items to eligible veterans. 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.

Entitled Person Details

1. **DVA file number**

2. **Surname**

3. **Given name(s)**

4. **Date of birth** / /

5. **Card type**

Gold ☐

White ☐

Conditions/disability to be treated (for white cards only)

Contact DVA to check eligibility under the client's Accepted Disability(ies) on 1300 550 457 (metro) 1800 550 457 (non metro).

6. **This request is for:**

Item	*Item Code Claiming*	*Details e.g. make, model no., lens design, material, supplier*	*Cost*
☐ Non schedule lens/frame/ contact lens			$
☐ Non schedule prisms (including Fresnel)			$
☐ Miscellaneous Item			$
☐ Low vision aid			$
☐ Item above price in DVA Fee Schedule			$

7. Client Eye/relevant Medical History (to include a brief summary, diagnosis, prognosis, corrected vision, previous and current spectacle prescriptions and dates of prescriptions).

Previous prescription date: / /

Right / x VA / Left / x VA / Add Prism

Current prescription date: / /

Right / x VA / Left / x VA / Add Prism

Relevant history/clinical details

8. Clinical justification for the request (including any exceptional/extenuating circumstances).

Provider Details

9. Provider name

10. Provider number

11. Provider type ☐ Optometrist ☐ Orthoptist ☐ Optical dispenser ☐ Ophthalmologist

12. Provider address

POSTCODE

13. Telephone number [ ]

14. Email address

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

Please attach separate pages as necessary.

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