Australian Government

Department of Veterans' Affairs

Reimbursement Claim Form
F-111 SHOAMP Health Care Scheme

Privacy Notice

Your personal information is protected by law, including the *Privacy Act 1988*. Your personal information may be collected by the Department of Veterans' Affairs (DVA) for the delivery of government programs 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.

Part A — Claimant Details

Title

Surname

Given name(s)

Postal address
(Including Postcode)

Postcode

Contact telephone

Work telephone ( )

Home telephone ( )

Mobile

Part B — SHOAMP Health Care Scheme Claim

Please complete the medical, pharmaceutical or travel claim sections (**below** and **overleaf**) and attach the documentation requested after each question.

If you have received a refund from Medicare Australia, your health fund or other third party, please attach the receipt or itemised statement of treatment/services.

Please keep a copy of all receipts for you records.

This claim will be paid by Direct Credit to your nominated Bank, Credit Union or Building Society account.

If you have any questions please contact the SHOAMP Health Care Scheme on 1800 728 007.

Part C — Claims Section

For all claim types listed on this form (Medical, Pharmaceutical and Travel claims) the **Benefit received** column refers to any benefit received from Medicare Australia, a Health Fund or any other third party.

Medical Claim

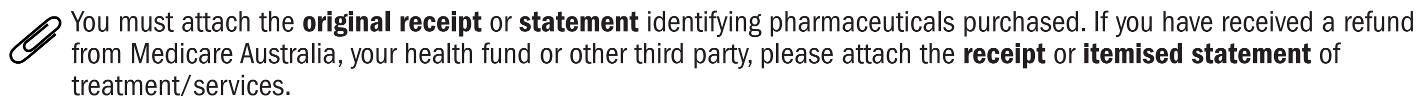
Date of service	Name of Medical Practitioner consulted	Condition Treated	Amount paid	Benefit received
/ /			$	$
/ /			$	$
/ /			$	$
/ /			$	$

You must attach the **original tax receipt** and **advice** from the practitioner identifying the condition that was treated. If you have received a refund from Medicare Australia, your health fund or other third party, please attach the **receipt** or **itemised statement** of treatment/services.

Continued on next page

Pharmaceutical Claim

Date of service	Pharmaceutical	Condition Treated	Amount paid	Benefit received
/ /			$	$
/ /			$	$
/ /			$	$
/ /			$	$
/ /			$	$

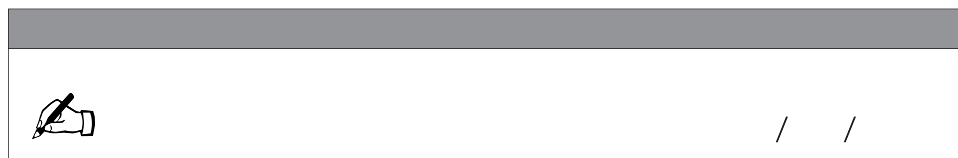


You must attach the **original receipt** or **statement** identifying pharmaceuticals purchased. If you have received a refund from Medicare Australia, your health fund or other third party, please attach the **receipt** or **itemised statement** of treatment/services.

Travel Claim

Date of service	Mode of travel	KMs travelled	Name of Medical Practitioner consulted	Condition treated
/ /				
/ /				
/ /				
/ /				

If claiming travel to attend VVCS counselling and/or programs, please ask VVCS to certify your attendance by signing below.

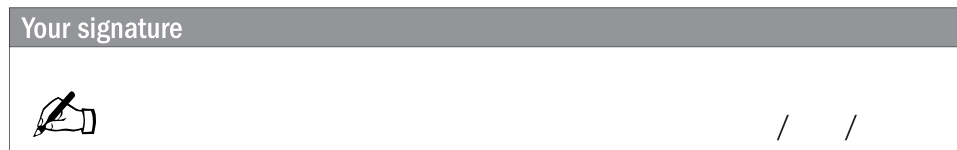


You must attach the **original receipt from the practitioner;** taxi, parking or public transport receipt. If you have received a refund from Medicare Australia, your health fund or other third party, please attach the **receipt** or **itemised statement** of treatment/services.

Part D Declaration

I declare that:

- I have incurred the expenses in the claim in accordance with the requirements of the SHOAMP Health Care Scheme.
- To the best of my knowledge, the information supplied in the claim form is true and correct.
- I am aware that there are penalties for making false or misleading statements.
- I authorise the SHOAMP Health Care Scheme to contact my medical provider for clarification of any details in this claim and consent to the medical provider releasing information to DVA to enable the processing of this claim.



Please send completed form to: **F-111 SHOAMP Health Care Scheme**
GPO Box 9998
Brisbane, QLD, 4001