

Application for Provisional Access to Medical Treatment (PAMT) Reimbursement

NOTE: All accounts must have been paid in full and itemised receipts need to be included with this application form for payment.

DVA will not reimburse repeat visits to a provider who does not accept DVA cards. As soon as possible, please locate a registered provider in your area who accepts DVA cards.

Further information on the PAMT trial can be found on the DVA website - www.dva.gov.au

Yo	ur Details								
1.	Title	Mr Mrs Ms Other							
2.	DVA File number								
3.	Surname								
4.	Given name(s)								
5.	Date of birth	DD MM YYYY							
6.	Postal address								
		State Postcode							
7.	Contact details	AREA CODE							
		Phone							
		Mobile							
		Email							
8.	If your DRCA/MRCA claim was declined after 1 July 2017, do you currently have an outstanding appeal?	No Yes							
Αŗ	plicant's bank details if	not currently in receipt of a DVA payment							
9.	Account name								
10.	BSB								
11.	Account number								
12.	Reason you paid for treatment?	DVA card not issued at the time of consult Treated overseas							
		Provider did not accept Treatment							
		White Card was not presented Other – please specify							

Details of Applicant, where	Delicitora	i y 13	uc		136	u	,, ,	4116	וטו		U	ihh	'i y						
13. Surname																			
14. Given name(s)										ĺ									
15. Postal address																			
								St	ate					Pos	tcoc	le		\perp	
16. Relationship to client (e.g. Advocate, Power of Attorney etc.)																			
17. Contact number	AREA CODE								Mobile										
18. Details of Medical Expense(s) being claimed																			
Full name and address of provider, ho pharmacy	spital or		ervico ed	-	Date of service			Cost of treatment			Benefit received from Medicare				Benefit received from Health Fund				
						/	/	\$			\$					\$			

\$

\$

\$

\$

\$

\$

\$

\$

\$

\$

Ś

\$

\$

\$

\$

Ś

Dotails of Applicant where beneficiary is deceased or unable to apply

- **Specialist Consults (i.e. Surgeon consults/MRI/Pet Scan)** all accounts must be accompanied by a referral from the doctor, the referral must state the reason for the treatment and/or specialist consultation.
- Doctors & Allied Health Services (i.e. GP, Physiotherapist, Dentist, Podiatrist, Spectacles, Footwear, Orthotics, Wound Dressings) all accounts must show the date and cost of each treatment and written clinical justification that treatment was related to your PAMT condition(s) for footwear, orthotics and wound dressings, written clinical justification must also be supplied.

TOTAL Reimbursement

- **Imaging (x-rays, scans) & Pathology (Blood Tests)** all accounts must show the date & cost of each treatment and be accompanied by a referral from the doctor who prescribed the treatment and the reason for the treatment type.
- Hospital Account including: private room/day procedure/facility fee all accounts must show the date of admission and
 discharge from hospital, state the nature of the condition treated, include an itemised list of all charges and be signed by
 the treating doctor.
- Pharmaceutical items, including: full-cost prescription and non-prescription medicines such as over-the counter items –
 not all pharmaceuticals are eligible for a refund. All receipts should be itemised dispensary receipts or supported by a copy of
 each related prescription.
- Aids, Appliances & home modifications (i.e. dressings, knee brace, hire of crutches, continence aids, compression garments all accounts must show the type of product supplied and be supported by a referral from the prescribing doctor. Where self-prescribing an aid/appliance a clinical explanation is required.
- Accounts reimbursed by Medicare or Private Health Insurance if you did not have a DVA health card issued at the time of
 your treatment and you have made a claim through Medicare or a private health insurer, you will need to ask for a statement of
 benefits paid, in order for DVA to consider reimbursement of any gap costs.

19. Additional Details														
If you need to provide additional														
information in relation to any part of your application, for example														
you need more space to detail your medical expenses privately														
incurred please provide a separate page or provide further														
relevant information here.														
Claimant's or authorised pe	rsons declaration													
am aware that there are penalties for mathematics and authorise the providers who have treated information related to the treatment listers the holder of a white card I certify the	orrect and I have received the goods and/or treatments listed naking false or misleading statements; and ed me or the beneficiary nominated on this form (select one) ed above; a treatment claimed is for an accepted disability as determine on to be accepted with the same authority as the original.	to disclose any												
Signature		Date												
	Ø	/ /												
Please send the completed form with all	the required information to:													
Department of Veterans' Affairs GPO Box 9998, Brisbane, QLD, 4001														
Email: Medtreat@dva.gov.au														