Australian Government
Department of Veterans' Affairs

DVA Request/Referral

All information requested on this form should be provided.

Please complete the patient's details, including address and date of birth if file number is not known.

This form should be used by the referring provider to:

- request prior approval from DVA, where necessary, for treatment services and the supply of rehabilitation appliances;
- refer directly to another provider where prior approval from DVA is not required; and
- request patient transport for travel to treatment services.

For detailed information on DVA's prior approval and other administrative requirements, please refer to the booklet "Notes for GPs", or contact DVA by phone.

Where prior approval from DVA is required, please send the comprehensive clinical details to DVA. The clinical details should include diagnosis and clinical findings. Please do not staple the clinical details to the form. If the request for prior approval is urgent, please contact DVA by phone.

Full clinical details are particularly important in relation to **requests for rehabilitation appliances.**

REFERRAL

Where bulk referral is appropriate, please send the any necessary clinical details directly to the provider.

The GP is responsible for checking the **eligibility** of patients to receive treatment at DVA expense. **White card holders** are entitled to receive treatment at DVA expense for their accepted disabilities only.

DVA will not be responsible for costs incurred where prior approval requirements are not followed, where ineligible patients are treated, or where a patient is treated by a provider who is not authorised to provide treatment on behalf of DVA.

If an indefinite referral to a medical specialist is appropriate for a chronically ill patient, the **period of referral** may be noted on the form as "ind".

The TRIPLICATE of this form is the **Transport Request Form**. It should be completed and returned to DVA when necessary.

The information provided on this form is required to process this request/referral. In the event of inappropriate servicing or treatment, or unprofessional conduct, information may be disclosed to the relevant State or Territory Registration Board or professional body.

Transport Request Form

The patient should use their usual, most economical, mode of public or private transport when travelling to treatment services.

Official car or taxi transport for treatment purposes will be provided only if a medical officer certifies that such transport is medically essential and that the patient cannot use satisfactory alternative transport.

If the patient is able to use public or private transport, this can be arranged without reference to DVA. Eligible patients can be reimbursed for privately incurred travel expenses if the treatment is approved and the patient attended the nearest suitable provider.

White card holders are only eligible for transport benefits in relation to treatment for their accepted disabilities.

D0904 01/20

PATIENT DETAILS

PLEASE COMPLETE THIS FORM ON YOUR COMPUTER THEN PRINT TO SIGN

FULL NAME

DATE OF BIRTH / /

ADDRESS

PHONE NO. ( )

File number

Patient's condition to be treated

Requesting/Referring Provider's name	Provider number

Address

Phone ( )

Provider's Signature / /

D904 01/20 – ORIGINAL

Australian Government
Department of Veterans' Affairs

DVA Request/Referral

The Specialist/Allied Health Provider referred to should:

1) complete their Provider Number details; and
2) attach the ORIGINAL of this form to their claim for payment.

DVA must be bulk billed for the relevant Government approved fee as **full payment** for services provided under this referral. No separate charge may be levied on an eligible patient.

DVA will not be responsible for costs incurred where prior approval requirements are not followed, where ineligible patients are treated, or where a patient is treated by a provider who is not authorised to provide treatment on behalf of DVA.

The DUPLICATE of this form should be attached to any **further referral**, and returned to DVA by that provider.

Specialist/Allied Health Provider's name	Provider number

Town/Suburb of Practice

Type of service required

☐ Specialist ☐ Rehabilitation Appliance ☐ Allied Health ☐ Other

Please specify which profession/specialty or appliance the treatment requires.

Please indicate whether the patient is: ☐ In a nursing home ☐ an in-patient ☐ in a hostel

Period of Referral .... months

cut on this line

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FULL NAME

DATE OF BIRTH / /

ADDRESS

PHONE NO. ( )

File number

Patient's condition to be treated

Requesting/Referring Provider's name	Provider number

Address

Phone ( )

Provider's Signature / /

D904 01/20 – DUPLICATE

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Requesting/Referring Provider's name	Provider number

Address

Phone ( )

Provider's Signature / /

D904 01/20 – TRIPLICATE

Australian Government
Department of Veterans' Affairs

Transport Request

Please read the information on the reverse of this page.

Please specify the medical reason(s) why official or taxi transport is requested:

Give medical reasons if the patient requires an attendant to travel to treatment:

Period transport required for: ☐ One appointment ☐ 3 months ☐ 6 months ☐ Indefinitely

If transport is to be arranged by DVA, please complete the following:

Appointment date ..../..../.... Appointment time ....

Place of appointment (include clinic/ward) ....

Patient's pick-up address ....

Is a return journey required? Yes ☐ No ☐

Is wheelchair transport required? Yes ☐ No ☐