IMPORTANT

Australian Government
Department of Veterans' Affairs

Reimbursement of Nursing Consumables over $1,000

Completing this form

This form is used to claim reimbursement for clients whose nursing consumables total exceeds $1,000 (ex GST) in a 28 day claim period. This form must be completed by a Registered Nurse (RN).

Where possible please complete and return this application form electronically.

If you are completing this form manually, please use BLACK pen to complete all information on this form.

The Department of Veterans' Affairs (DVA) cannot assess an incomplete or illegible form.

Contacting the Community Nursing team

If you require assistance completing this form, please email DVA at exceptional.cases@dva.gov.au

Submitting this form

Form submission is via DVA's secure email.

Please email exceptional.cases@dva.gov.au to set up secure email facilities.

Please refer to the below link for information about secure email:
http://www.dva.gov.au/site-help/sensitive-emails

Note

A copy of the current **nursing care plan** including all relevant assessments must be provided with this application to enable processing.

If the consumables claim is in relation to wound care, an *Exceptional Case Application Attachment 4 - Wound Care* form and current wound images (see Attachment 4 for full details) must be provided. This can be found at https://www.dva.gov.au/providers/health-programs-and-services-our-clients/community-nursing-services-and-providers-2.

You must provide a breakdown of individual item costs for the items being claimed. At any time DVA reserves the right to request evidence of the product costs, i.e. supply invoices. There is an upper limit of $1,500 for consumables per claim period.

Privacy Notice

The person completing this form is responsible for ensuring that the client is aware that:

- their information will be forwarded to DVA for determining benefits under the *Veterans' Entitlements Act 1986* and/or the *Military Rehabilitation and Compensation Act 2004*
- information, in certain circumstances, may be used for review or audit purposes or be disclosed to the person's General Practitioner (GP), specialist or other health professional, and
- information will be treated in a confidential manner.

Read more about how DVA manages personal information at
https://www.dva.gov.au/about-us/overview/legal-resources/privacy

PART A Community Nursing Provider Information

1. Provider details

Provider name

Provider number

Provider site

Contact number [ ]

Contact email

2. GP/Specialist details

Doctor's name

Doctor's contact number [ ]

Provider number

3. Referrer details

Referrer's name

Referrer's contact number [ ]

PART B Client Information

4. Client information

DVA file number

Surname

Given name(s)

Date of birth

Address

POSTCODE

Specify type of accommodation

- ☐ Private residence
- ☐ Independent Living Unit (ILU)

5. Medical condition(s)

PART C Health History

6. Relevant clinical conditions and nursing consumables

List client's relevant clinical condition(s) and the justification for the nursing consumables used. If the nursing consumables are available through the Rehabilitation Appliances Program (RAP) (see https://www.dva.gov.au/providers/rehabilitation-appliances-program-rap/rap-schedule) or the Repatriation Pharmaceutical Benefits Scheme (RPBS) (see https://www.pbs.gov.au/browse/rpbs) schedule, please provide the reason why the RAP or RPBS schedule was not used

PART D Claiming Information

7. 28 day claim period commencement date

8. Previous 28 day claim period item number(s) (from Schedule of Fees)

9. Total amount (ex GST)

10. Additional comments

DVA file No.

PART E Attachments and Declaration

11. Attachments

Please complete and attach the following

Attached

- ☐ Nursing care plan (required)
- ☐ Breakdown of item costs and/or invoice (required)
- ☐ Attachment 4 - Wound Care form with requested photos (if applicable)

12. Declaration

I declare that the information I have supplied on this form and on any other attachments is true and correct.

I am aware that there are penalties for making false statements. *(Refer to Notes for Community Nursing Providers - Inappropriate claiming.)*

Declaration must be signed by the RN completing this form.

Full name	
Title	
Signature *(electronic signature accepted)*	
Date	

Please note, no further changes can be made once form has been electronically signed.

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