Australian Government
Department of Veterans' Affairs

Claim for Travelling Expenses

Use this form for

travel relating to Treatment, a Disability Claim or an Income Support Claim under the *Veterans' Entitlements Act 1986*, or treatment under the *Australian Participants in British Nuclear Tests (Treatment) Act 2006*.

Do NOT use this form for

travel relating to the Administrative Appeals Tribunal, the Veterans' Review Board or the Specialist Medical Review Council. Use the D803 form for these purposes – contact your State Office or Veterans' Affairs Network (VAN) office.

Information

For information, please read the DVA fact sheets, available from your State Office or VAN, or visit our website www.dva.gov.au Refer to Factsheet HSVO2.

Privacy

The information provided on this form is required to assess your claim for travelling expenses under the *Veterans' Entitlements Act 1986* and *Australian Participants in British Nuclear Tests (Treatment) Act 2006*. The Acts require that a claim be made on this form as approved by the relevant Commonwealth bodies.

We may disclose some of the information provided on this form to your health provider, Medicare Australia or other providers in order to verify your claim. We may also provide information to the Department of Finance and Deregulation to facilitate payment of your claim.

Filling in your claim

You must complete all relevant questions in the **CLAIMANT** sections, and your health provider must complete the **HEALTH PROVIDER** section when travelling over 100km return. You may claim travelling expenses online by visiting www.dva.gov.au.

Please complete a separate form for each health provider.

Please retain your transport receipts (over $30) for 4 months. You may be requested to provide them to DVA during this period.

Complete this form carefully as an incorrect and/or incomplete form may be returned to you for completion.

Claim period

To receive payment for travel, you must lodge the form within **12 months** after completion of travel.

Contact details

1300 550 454 (metro) **1800 550 454** (country)

Please send your completed form to:

Department of Veterans' Affairs
GPO 9998 in your State capital city
OR fax to: **(07) 3223 8402** OR scan and e-mail to: **transportclaims@dva.gov.au**

Claimant's details

Your surname	
Given names	
DVA File Number	
Contact phone	[ ]
E-mail address	
Home address	
	POSTCODE
Postal address *(if different from home address)*	
	POSTCODE

If you are a person authorised to act on behalf of the claimant in matters relating to this claim, please give full name and address.

Full name	
Address	
	POSTCODE

Attach accommodation receipts

Claimant's Section

Trip 1

Date / /

Time am/pm

Which Health Provider did you attend?

Type of provider

Name of provider

Suburb

What is the trip for?

☐ Treatment ☐ Disability claim

☐ Hospital ☐ Income Support

For the return trip - what are you claiming?

Private vehicle	km
Public transport	$
Taxi	$
Community	$
Air	$
Parking fees	$
Road Tolls	$

Did DVA arrange/pay for this travel?
(e.g. booked car with driver, air travel or ambulance)

No ☐ Yes ☐

Did you require accommodation? *(Attach accommodation receipts)*

No ☐ Yes ☐ ▸ Type of accommodation

☐ Commercial

☐ Private

☐ Subsidised

Length of stay nights

Did you travel with a medically required attendant?

No ☐ Yes ☐ ▸ Name of medically required attendant

Trip 2

Date / /

Time am/pm

Which Health Provider did you attend?

Type of provider

Name of provider

Suburb

What is the trip for?

☐ Treatment ☐ Disability claim

☐ Hospital ☐ Income Support

For the return trip - what are you claiming?

Private vehicle	km
Public transport	$
Taxi	$
Community	$
Air	$
Parking fees	$
Road Tolls	$

Did DVA arrange/pay for this travel?
(e.g. booked car with driver, air travel or ambulance)

No ☐ Yes ☐

Did you require accommodation? *(Attach accommodation receipts)*

No ☐ Yes ☐ ▸ Type of accommodation

☐ Commercial

☐ Private

☐ Subsidised

Length of stay nights

Did you travel with a medically required attendant?

No ☐ Yes ☐ ▸ Name of medically required attendant

Claimant's or Authorised Person's Declaration

I declare that the details I have provided in this form are correct to the best of my knowledge.

I understand that giving false or misleading information is a serious offence.

Claimant's or authorised person's signature

Date / /

Health Provider Section

Please complete if the distance travelled was greater than 100km return.

Reason(s) for visit(s): ☐ Treatment ☐ Disability claim ☐ Income support claim

Trip 1

To the best of your knowledge, are you the closest practical provider able to administer the required treatment?

No ☐ Yes ☐

If the claimant is a WHITE card holder, were they treated for a condition related to their accepted disabilities?

No ☐ Yes ☐

I certify that I have provided treatment on the date shown and that the details I have provided are correct.

Health provider signature

✍

Date

/ /

If you are signing on behalf of the provider, provide your full name

Trip 2

To the best of your knowledge, are you the closest practical provider able to administer the required treatment?

No ☐ Yes ☐

If the claimant is a WHITE card holder, were they treated for a condition related to their accepted disabilities?

No ☐ Yes ☐

I certify that I have provided treatment on the date shown and that the details I have provided are correct.

Health provider signature

✍

Date

/ /

If you are signing on behalf of the provider, provide your full name

Provider type

Surname and initials

Treatment location

POSTCODE

Telephone number [ ]

Provider number

Provider stamp (if preferred)

Additional information

Please use this page for any additional information.