



# D800

# Claim for Travelling Expenses

## Use this form for

travel relating to treatment or a disability claim.

## Do NOT use this form for

travel relating to the Administrative Appeals Tribunal, the Veterans' Review Board or the Specialist Medical Review Council. Use a different form – 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](http://www.dva.gov.au)

## Filling in your claim

**Complete a separate form for each health provider visited.**

You must complete the **VETERAN** parts, and your doctor or other health provider must complete the **DOCTOR** or **HEALTH PROVIDER** parts.

For **ADMISSION TO HOSPITAL**, please refer to page 3.

Please print neatly in **BLOCK LETTERS** using a **BLACK** or **BLUE PEN**.

## Claim period

To receive payment for travel, you must lodge the form within:

**12 months** after completion of travel for a visit to treatment;

**3 months** after completion of travel for a visit in connection with a disability claim.

## Send your claim to

**Department of Veterans' Affairs**  
**GPO Box 9998 in your State capital city.**

## Privacy

The information provided is required to assess your claim for travelling expenses under the *Veterans' Entitlements Act 1986*. The Act requires that a claim be made on this form as approved by the Repatriation Commission. We may disclose some of the information provided on this form to your doctor or health provider, or to Medicare Australia in order to verify your claim. We may also provide information to the Department of Finance and Administration to facilitate payment of your claim.

### Veteran to complete and sign

Your surname

Given names

DVA File Number

Contact phone

#### HOME ADDRESS

Number and street

Suburb/town

Postcode

#### POSTAL ADDRESS (if different to home address)

Number and street

Suburb/town

Postcode

#### DECLARATION

I declare that the details I have provided in this form are correct to the best of my knowledge.  
I have attached all required receipts to this form.  
I understand that giving false or misleading information is a serious offence.

YOUR SIGNATURE

Date

If you are a person authorised to act on behalf of the veteran in matters relating to this claim, please give your name

## Remember!

- Attach** all required receipts.
- Complete and sign** the section above.
- Lodge** your form within the specified claim period.

Office use

Claim ID

Amount paid

\$

Use this page to claim for visits for treatment or a disability claim.  
For admission to hospital, please use page 3.

Fix receipts here



Should further visits be required, please reprint page 2.

VETERAN to complete	VISIT 1	VISIT 2																																												
Date and time of visit	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> am/pm	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> am/pm																																												
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Did you travel FROM HOME?	Yes <input type="checkbox"/> No <input type="checkbox"/> If you answered 'No', write the address you travelled from <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> If you answered 'No', write the address you travelled from <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/>																																												
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DOCTOR or other HEALTH PROVIDER to complete	VISIT 1	VISIT 2
Specify condition treated (for <b>White Card</b> only)	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
For each visit, indicate any special requirements due to veteran's medical condition	Unable to use private vehicle or public transport? Yes <input type="checkbox"/> No <input type="checkbox"/> Attendant medically required? Yes <input type="checkbox"/> No <input type="checkbox"/>	Unable to use private vehicle or public transport? Yes <input type="checkbox"/> No <input type="checkbox"/> Attendant medically required? Yes <input type="checkbox"/> No <input type="checkbox"/>
By signing for each visit, you, the doctor/health provider certify that you saw the veteran for treatment that day and the details entered are correct	<input style="width: 100%;" type="text"/> Date <input type="text"/> / <input type="text"/> / <input type="text"/>	<input style="width: 100%;" type="text"/> Date <input type="text"/> / <input type="text"/> / <input type="text"/>

Before this claim can be lodged	Type of provider <input style="width: 100%;" type="text"/>
Please make sure you (the doctor or other health provider) have completed ALL of the following details	Provider number <input style="width: 100%;" type="text"/>
	Reason for visit(s): Treatment <input type="checkbox"/> Disability claim <input type="checkbox"/>
	To the best of your knowledge, did the treatment meet the health care needs of the veteran and are you the <b>closest practicable</b> provider able to administer the required treatment? Yes <input type="checkbox"/> No <input type="checkbox"/>
	STAMP OR PRINT
	Provider's surname & initials <input style="width: 100%;" type="text"/>
	Full address at which treatment occurred <input style="width: 100%;" type="text"/>
	Postcode <input style="width: 100%;" type="text"/>
	Contact phone <input style="width: 100%;" type="text"/>

Remember! You must lodge your form within the specified claim period.

# ADMISSION TO HOSPITAL

For other types of visits, please use the other page.

<b>VETERAN to complete</b>	<b>ADMISSION</b>	<b>DISCHARGE</b>
<p style="text-align: center;">Dates and times</p> <p>Give details of all transport, parking and road tolls used.</p> <p>Give separate details for the trip there (for admission) and the trip back (after discharge).</p> <ul style="list-style-type: none"> <li>Public transport = bus, tram, train, ferry</li> <li>Community = transport by a community organisation</li> <li>Arranged by DVA = transport supplied or paid by DVA</li> </ul> <p><b>• No receipts are needed for expenses under \$10</b></p>	<div style="text-align: right; margin-bottom: 5px;"> <input type="text"/> / <input type="text"/> / <input type="text"/> am / pm         </div> <p><b>TRANSPORT FOR ADMISSION ONLY</b></p> <p>Private vehicle <input type="text"/> km</p> <p>Public transport \$ <input type="text"/></p> <p>Taxi \$ <input type="text"/></p> <p>Community \$ <input type="text"/></p> <p>Air \$ <input type="text"/></p> <p>Parking fees \$ <input type="text"/></p> <p>Road tolls \$ <input type="text"/></p> <p>Ambulance <input type="checkbox"/></p> <p>Arranged by DVA <input type="checkbox"/></p>	<div style="text-align: right; margin-bottom: 5px;"> <input type="text"/> / <input type="text"/> / <input type="text"/> am / pm         </div> <p><b>TRANSPORT AFTER DISCHARGE ONLY</b></p> <p>Private vehicle <input type="text"/> km</p> <p>Public transport \$ <input type="text"/></p> <p>Taxi \$ <input type="text"/></p> <p>Community \$ <input type="text"/></p> <p>Air \$ <input type="text"/></p> <p>Parking fees \$ <input type="text"/></p> <p>Road tolls \$ <input type="text"/></p> <p>Ambulance <input type="checkbox"/></p> <p>Arranged by DVA <input type="checkbox"/></p>
<p>Did you travel FROM HOME? Yes <input type="checkbox"/> No <input type="checkbox"/> What address did you travel from? <input style="width: 100%;" type="text"/></p>		
<p>Accommodation used for this visit</p> <ul style="list-style-type: none"> <li>Commercial = hotel, motel etc.</li> <li>Subsidised = hostel, special hospital unit etc.</li> <li>Private = family, friends, etc.</li> </ul> <p>Number of nights: Commercial <input type="text"/> Subsidised <input type="text"/> Private <input type="text"/></p> <p style="text-align: right;">Attach receipts</p>		
<p>Did you travel with an ATTENDANT? No <input type="checkbox"/> Yes <input type="checkbox"/> Give details</p> <p>Name of your attendant <input style="width: 100%;" type="text"/></p> <p>Did your attendant travel home and then return for you on discharge? No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>Number of nights your attendant used COMMERCIAL accommodation while you were in hospital <input type="text"/> Attach receipts – a contributing allowance may be paid by DVA</p>		

<b>HOSPITAL to complete</b>	<b>ADMISSION</b>	<b>DISCHARGE</b>
<p>Indicate any special requirements due to veteran's medical condition <input style="width: 20px;" type="checkbox"/></p>	<p>Unable to use private vehicle or public transport? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Attendant medically required? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Unable to use private vehicle or public transport? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Attendant medically required? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>STAMP OR PRINT</p>		<p>Specify condition treated (for <b>White Card</b> only)</p> <input style="width: 100%; height: 20px;" type="text"/>
<p>Hospital name <input style="width: 100%;" type="text"/></p> <p>Address at which treatment occurred</p> <p>No. &amp; street <input style="width: 100%;" type="text"/></p> <p>Suburb/town <input style="width: 100%;" type="text"/></p> <p>Contact phone <input style="width: 100%;" type="text"/></p> <p>Provider Number for treatment address <input style="width: 100%;" type="text"/></p>	<p>Postcode <input style="width: 100%;" type="text"/></p>	
<p>Admitting doctor <input style="width: 100%;" type="text"/></p>	<p>Type of provider <input style="width: 100%;" type="text"/></p>	<p><b>CERTIFICATION</b></p> <p>I certify that I have provided treatment on the dates shown and that the details I have provided are correct.</p> <p>Signature <input style="width: 100%; height: 40px;" type="text"/></p> <p>Print name <input style="width: 100%;" type="text"/></p> <p>Date <input style="width: 100%;" type="text"/></p>
<p>To the best of your knowledge, did the treatment meet the health care needs of the veteran and are you the <b>closest practicable</b> provider able to administer the required treatment? Yes <input type="checkbox"/> No <input type="checkbox"/></p>		