



D800

Claim for Travelling Expenses

Use this form for

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

Note: for reimbursement of travel to be payable a cost **MUST** be incurred - e.g. free travel cannot be reimbursed.

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

Privacy

The information provided on this form is required to assess your claim for travelling expenses under the appropriate Acts. 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 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 Deregulation to facilitate payment of your claim.

Filling in your claim

Complete a separate form for each health provider visited.

You must complete the **CLAIMANT** sections on **pages 2 and 3**, and your doctor or other health provider must complete the **HEALTH PROVIDER** section on **page 4**.

For **ADMISSION** or **DISCHARGE TO HOSPITAL** please provide details on **pages 5 and 6** and the hospital must complete **page 6**.

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

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

Claimant to complete

Your surname

Given names

DVA File Number

Contact phone

HOME ADDRESS

Number and street

Suburb/town

State

POSTCODE

POSTAL ADDRESS (if different to home address)

Number and street

Suburb/town

State

POSTCODE

Claimant's 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.

For your claim to be accepted, you must sign and date this form.

CLAIMANT'S SIGNATURE



/ /

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

Full name

Address

POSTCODE

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 or Income Support Claim.

Send your claim to

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

Claimant's travel details

Visit details

Give details of all transport, parking and road tolls used. **For each visit** ensure that the total provided is for the **return trip** (i.e. there and back). **No receipts are required for expenses under \$30**

Visit 1

Date / / Time am/pm

Private vehicle	<input type="text"/>	km
Public transport	<input type="text"/>	\$
Taxi	<input type="text"/>	\$
Community	<input type="text"/>	\$
Air	<input type="text"/>	\$
Parking fees	<input type="text"/>	\$
Road Tolls	<input type="text"/>	\$

Attach receipts if \$30 or over

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

No Yes

If you did not travel from home, provide the address you travelled from

POSTCODE

Visit 2

Date / / Time am/pm

Private vehicle	<input type="text"/>	km
Public transport	<input type="text"/>	\$
Taxi	<input type="text"/>	\$
Community	<input type="text"/>	\$
Air	<input type="text"/>	\$
Parking fees	<input type="text"/>	\$
Road Tolls	<input type="text"/>	\$

Attach receipts if \$30 or over

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

No Yes

If you did not travel from home, provide the address you travelled from

POSTCODE

Visit 3

Date / / Time am/pm

Private vehicle	<input type="text"/>	km
Public transport	<input type="text"/>	\$
Taxi	<input type="text"/>	\$
Community	<input type="text"/>	\$
Air	<input type="text"/>	\$
Parking fees	<input type="text"/>	\$
Road Tolls	<input type="text"/>	\$

Attach receipts if \$30 or over

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

No Yes

If you did not travel from home, provide the address you travelled from

POSTCODE

Distance from home details

For **all transport types** where the distance is greater than 100kms (there and back), how far is your home or temporary residence from the treatment location?

km

For **all transport types** where the distance is greater than 100kms (there and back), how far is your home or temporary residence from the treatment location?

km

For **all transport types** where the distance is greater than 100kms (there and back), how far is your home or temporary residence from the treatment location?

km

Attendant details

Did you travel with an attendant?

No Yes Name of attendant

Address of attendant

POSTCODE

Did you travel with an attendant?

No Yes Name of attendant

Address of attendant

POSTCODE

Did you travel with an attendant?

No Yes Name of attendant

Address of attendant

POSTCODE

Continued on page 3 

Health Provider to complete

Before this claim can be lodged, please make sure you, as the health provider have completed **ALL** of the details below

Visit 1

For WHITE CARD holders only - was the condition treated related to any of the claimant's accepted disabilities?

No Yes

Was private, public or community transport medically unsuitable?

No Yes

Was an attendant medically required?

No Yes

Visit 2

For WHITE CARD holders only - was the condition treated related to any of the claimant's accepted disabilities?

No Yes

Was private, public or community transport medically unsuitable?

No Yes

Was an attendant medically required?

No Yes

Visit 3

For WHITE CARD holders only - was the condition treated related to any of the claimant's accepted disabilities?

No Yes

Was private, public or community transport medically unsuitable?

No Yes

Was an attendant medically required?

No Yes

Tick if the claimant is legally blind or suffering dementia

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

No Yes

Reason for visit(s) Treatment Disability Claim Income Support Claim

I certify that I have provided treatment on the dates 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 below

HEALTH PROVIDER SIGNATURE



Date

/ /

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

HEALTH PROVIDER SIGNATURE



Date

/ /

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

Health Provider details

Provider type

Provider number

Ensure address details provided are that **at which the treatment occurred**

Surname and initials

Treatment location address

POSTCODE

Telephone number

[]

Provider stamp (if preferred) or print

Refer to page 5 when claiming for hospital travel >>>

Claimant's hospital travel details

Admission/Discharge details

Give details of all transport, parking and road tolls used. **For hospital admission/discharge** ensure that the total provided is for a **one way** trip. If your authorised attendant travels home upon your admission, also provide their travel details (home and back). **No receipts are required for expenses under \$30**

Admission

Date / / Time am/pm

Private vehicle	<input type="text"/> km	Attach receipts if \$30 or over
Public transport	\$ <input type="text"/>	
Taxi	\$ <input type="text"/>	
Community	\$ <input type="text"/>	
Air	\$ <input type="text"/>	
Parking fees	\$ <input type="text"/>	
Road Tolls	\$ <input type="text"/>	

Did DVA arrange/pay for this travel (e.g. booked car with driver or air travel)? No Yes

Did you travel by ambulance? No Yes

Discharge

Date / / Time am/pm

Private vehicle	<input type="text"/> km	Attach receipts if \$30 or over
Public transport	\$ <input type="text"/>	
Taxi	\$ <input type="text"/>	
Community	\$ <input type="text"/>	
Air	\$ <input type="text"/>	
Parking fees	\$ <input type="text"/>	
Road Tolls	\$ <input type="text"/>	

Did DVA arrange/pay for this travel (e.g. booked car with driver or air travel)? No Yes

Did you travel by ambulance? No Yes

If you did not travel from home, provide the address you travelled from
 POSTCODE

How far is your home or temporary residence from the treatment location (**there and back**)? km

Attendant details

Did you travel with an attendant? No Yes Name and address of attendant

 For Hospital Admission, how far is your attendant's residence from the hospital? km
 POSTCODE

Accommodation details

Types of accommodation

- Private = family, friends etc.
- Subsidised = hostel, special hospital unit etc.
- Commercial = hotel, motel etc.

Please specify type of accommodation used by you and your authorised attendant, length of stay and date of first night.

Admission

	Number of nights	Date of first night	Attach receipts
Private	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	
Subsidised	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	
Commercial	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	

Is this commercial accommodation in a capital city? No Yes

Did you stay in separate commercial accommodation when travelling with an attendant? No Yes

Discharge

	Number of nights	Date of first night	Attach receipts
Private	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	
Subsidised	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	
Commercial	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	

Is this commercial accommodation in a capital city? No Yes

Did you stay in separate commercial accommodation when travelling with an attendant? No Yes

Accommodation details *continued...*

Did your attendant travel home while you were in hospital and then return for you on discharge?

No

Yes ► Please ensure that you have provided your attendant's travel details on page 5

Did your attendant stay in accommodation while you were in hospital?

No Yes ► Please specify type of accommodation used by your attendant only, length of stay and date of first night below

	Number of nights	Date of first night
Private	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Subsidised	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Commercial	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Attach receipts

NOTE: DVA may pay a contributing allowance towards accommodation based on a comparison between the distance from the attendant's home and the number of nights of accommodation

Hospital to complete

Before this claim can be lodged, please make sure you, as the health provider have completed **ALL** of the details below

For WHITE CARD holders only - was the condition treated related to any of the claimant's accepted disabilities? No Yes

Admission

Was private, public or community transport medically unsuitable? No Yes

Was an attendant medically required? No Yes

Discharge

Was private, public or community transport medically unsuitable? No Yes

Was an attendant medically required? No Yes

Tick if the claimant is legally blind or suffering dementia

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

No Yes

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

HOSPITAL SIGNATURE

 / /

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

HOSPITAL SIGNATURE

 / /

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

Hospital details

Provider type

Provider number

Ensure address details provided are that **at which the treatment occurred**

Surname and initials

Provider stamp (*if preferred*) or print

Treatment location address

POSTCODE

Telephone number

[]