



## Please read before completing this claim form:

- **Do not** complete this form if you have claimed or are entitled to claim benefits in relation to your treatment under any other Commonwealth, state or territory scheme (TAC, Insurance or WorkCover).
- Your application will be assessed on the basis of the information you provide, please read it carefully before you start.
- Claim forms must be submitted **within 12 months** from the first treatment date listed on this form.
- **Trips taken after the approved medical specialist or authorised officer has signed and dated this form in Section C will not be paid.**



## Section A: Travel and accommodation diary

- All original public transport tickets/receipts/flight itineraries and invoices must be attached. Petrol receipts are not required.
- All original accommodation invoices must be attached; EFTPOS and Credit Card receipts are not classed as an acceptable invoice.
- All trips will be calculated from the residential address provided in **Section B**.
- No reimbursements are provided for private accommodation. Commercial/subsidised accommodation is accommodation that is registered as a business and has an Australian Business Number (ABN).
- Additional copies of the travel and accommodation diary are available from your Department of Health regional office or follow the links on our website <www.health.vic.gov.au/ruralhealth>.

People travelling		Trip type		Transport type			Accommodation type				
P = Patient	E = Escort	S = Single (one way)	A = Aeroplane	C = Car	T = Taxi	PV = Private					
P/E = Patient and Escort	R = Return	EM = Air/road ambulance	P = Public Transport (v-line, metlink)			C = Commercial/subsidised					

  

Travel							Accommodation				
Journey start date	Journey end date	Where was treatment/consultation received? (Provide full address of where treatment was received)	People travelling	Trip type	Transport type	Treatment date(s)	Was patient hospitalised?	Hospital admission date	Hospital discharge date	Accomm. type	Accomm. dates
18/01/12	21/01/12	Hospital Name, Street Address, Suburb/City, Postcode	P/E	R	C	start 19/01/12 end 21/01/12	yes	19/01/12	21/01/12	C	start 18/01/12 end 21/01/12
/ /	/ /					start / / end / /	yes	/ /	/ /		start / / end / /
/ /	/ /					start / / end / /	yes	/ /	/ /		start / / end / /
/ /	/ /					start / / end / /	no	/ /	/ /		start / / end / /
/ /	/ /					start / / end / /	yes	/ /	/ /		start / / end / /

## Section B: Patient (Complete in BLOCK CAPITALS)

Title Mr  Mrs  Miss  Ms

Given name

Middle name

Family name

Gender Male / Female

Date of birth / /

Are you of Aboriginal or Torres Strait Islander descent? Yes  No

Residential address

Postcode

Postal address

Postcode

Phone  or

Do you have a current pension concession card, health care card or DVA card?

Yes  No  If yes, card number

Card expiry date / /

Have you made a previous claim for VPTAS? Yes  No

How many return trips are you claiming for on this claim form?

Did you have an escort? Yes  No

### Escort's details

Given name

Middle name

Family name

## Section C: Approved medical specialist (Authorised officer may complete this on behalf of the approved medical specialist but please ensure specialist's name is listed)

Specialist name

Type of specialist

Specialist provider number

• Does the patient require an escort? Yes  No

• **An escort is responsible for the patient's transport and accommodation needs during treatment.**

• Excluding hospitalisation, how many nights is it medically necessary for the patient to stay in commercial or subsidised accommodation for all treatment journeys listed on this claim form?  **nights.**

• If other immediate family members are required to attend the same session for medical treatment or consultation (family support), the approved medical specialist must provide a letter outlining the details. See below.

• **Patients may be eligible for family support assistance where the approved medical specialist requires immediate family members (parents or guardians, partners and/or siblings) to attend the same session for medical treatment or consultation.**

• **Details of family support need to be confirmed in writing by the approved medical specialist.**

Signature of treating medical specialist or authorised officer.

Signature .....

Name .....

Position .....

Date / / Direct contact (ph)

With consent, the department may contact you to clarify information relating to the patient's claim.

• **This section must be signed and dated by the approved medical specialist or authorised officer on or after the last treatment/consultation date listed in Section A.**

• **Please ensure that if an additional travel and accommodation diary is attached to this claim form that it is also signed on or after the last listed date of specialist medical services.**

• **Note: An authorised officer is an individual that works with/for the approved medical specialist and can confirm the information provided in Section A and C.**

Specialist stamp here (if applicable):

## Section D: Consent and declaration

**Section D must be completed for VPTAS to be able to process your claim.**

When assessing your VPTAS application it may be necessary to discuss your application with other relevant parties. Your consent is required to permit the department to discuss your VPTAS application. Any information you provide on your application will remain confidential.

Only details which directly relate to your VPTAS application will be discussed. The release of information from relevant parties is for the sole purpose of clarifying issues relating to your application for VPTAS assistance and for no other purpose.

**By printing and signing my name below, I:**

- declare that the information provided is true and correct and understand that if I have provided a false declaration I may be liable to penalties of perjury under the *Evidence Act 1958*, which may include imprisonment.
- authorise the Department of Health or officers acting on behalf of the department to discuss information regarding my VPTAS application with my medical specialist or other relevant parties as necessary.

Patient or legal guardian to print name .....

Signature .....

Date / / .....

**Please ensure you have completed all sections of the claim form and attached all relevant documents.**

## Section E: Payment

Please tick a payment option: EFT  Cheque

For travel  and/or accommodation

### Electronic funds transfer

I have been paid EFT before and my details are the same:

Yes  No

(If you answered 'No' please complete the details below).

If you would like the details of your EFT payment to be emailed to you, please provide your email address:

Account name

BSB

Account number

### By cheque

Full name and postal address to which cheque is to be made.

Name

Postal address

Postcode

### Payment to other provider

For travel  and/or accommodation

Full business name and address to which cheque is to be made.

Business name

Postal address

Postcode

## Claim lodgement

Send your completed claim to:

Victorian VPTAS office

PO Box 712, Ballarat 3353

Freecall: 1300 737 073

Phone: 5333 6040

Claim forms can be collected and submitted at your local Department of Health office. Claim forms can be accessed and ordered on-line at <[www.health.vic.gov.au/ruralhealth](http://www.health.vic.gov.au/ruralhealth)>

## Accessibility

If you would like to receive this publication in an accessible format, please phone 5333 6040 using the National Relay Service 13 36 77 if required.

## Privacy

The Department of Health (Department) is committed to protecting your privacy. We collect and handle personal information in this form for the purposes of administering and processing payments for your VPTAS claim. If you choose not to provide your personal information or only provide part of the information requested, we may not be able to process your claim.

You have a right to access your personal information through the *Freedom of Information Act 1982*.\*

For information on the Department's privacy policy, please visit the Department's privacy website on <[www.dhs.vic.gov.au/pdpc/ciiru/privacy](http://www.dhs.vic.gov.au/pdpc/ciiru/privacy)>.

\* For information about Freedom of Information (FoI) requests, visit the Department's FOI website <[www.dhs.vic.gov.au/foi](http://www.dhs.vic.gov.au/foi)>