Australian Government

Department of Veterans' Affairs

NOTES FOR ALLIED HEALTH PROVIDERS

SECTION ONE: GENERAL

These Notes are applicable to the following providers:

- Chiropractors
- Clinical Psychologists
- Dentists, Dental Specialists and Dental Prosthetists
- Diabetes Educators
- Dietitians
- Exercise Physiologists
- Neuropsychologists
- Occupational Therapists
- Occupational Therapists (Mental Health)
- Optometrists, Orthoptists and Optical Dispensers
- Orthotists
- Osteopaths
- Physiotherapists
- Podiatrists
- Psychologists (Registered and Clinical)
- Social Workers (General)
- Social Workers (Mental Health)
- Speech Pathologists

I, Elizabeth Cosson AM, CSC Secretary of the Department of Veterans' Affairs (DVA) hereby:

(a) revoke the Notes for Allied Health Providers 10 December 2020; and

(b) approve these Notes to commence on 1 January 2022.

Elizabeth Cosson AM CSC

Dated this Thursday 16th of December 2021

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The purpose of the Notes for Providers

1. The Department of Veterans' Affairs (DVA) recognises that health care providers play a key role in providing treatment for entitled persons. These 'Notes for Providers' (Notes) have been developed to define the parameters for providing health care services to entitled persons [see clause 11 for definition] and to describe the relationship between the Department, patient and the provider. The Notes also refer to the relationship between allied health providers and general practitioners (GPs).
2. These Notes provide information about the provision of services to entitled persons by the allied health providers. In these Notes, the terms allied health provider and health care provider are used to refer to the following providers:
    - chiropractors;
    - clinical psychologists;
    - dentists, dental specialists and dental prosthetists;
    - diabetes educators;
    - dietitians;
    - exercise physiologists;
    - neuropsychologists;
    - occupational therapists;
    - occupational therapists (mental health);
    - optometrists, orthoptists and optical dispensers;
    - orthotists;
    - osteopaths;
    - physiotherapists;
    - podiatrists;
    - psychologists (registered and clinical);
    - social workers (general);
    - social workers (mental health); and
    - speech pathologists.
3. These Notes explain the procedures to be followed when health care providers render services to entitled persons under the following legislation:
    - *Veterans' Entitlements Act 1986* (VEA); or
    - *Military Rehabilitation and Compensation Act 2004* (MRCA); or
    - *Australian Participants in British Nuclear Tests and British Commonwealth Occupation Force (Treatment) Act 2006* (APBNT&BCOF(T)A); or
    - *Treatment Benefits (Special Access) Act 2019*.

    These are collectively referred to as "the Acts".

The Commissions and the Department of Veterans' Affairs

4. The Repatriation Commission and the Military Rehabilitation and Compensation Commission (MRCC), collectively referred to as 'the Commissions', administer the

Acts. DVA undertakes the administration of the Acts on behalf of the Commissions.

5. Under the Acts, the Commissions are authorised to prepare legislative instruments called the Treatment Principles as documents legally binding on providers, entitled persons and the Commissions. The Treatment Principles set out the circumstances under which financial responsibility is accepted for the health care treatment of entitled persons.

Status of the Notes

6. These Notes are incorporated by reference into the Treatment Principles and set out the conditions under which health care providers may provide treatment to entitled persons under DVA's health care arrangements.

7. Health care providers are required to deliver treatment and meet the accountability requirements as set out in these Notes. Any breach of these Notes may lead to action such as non-payment of claims or recovery of monies from claims previously paid, or where serious breaches are identified, the matter may be referred to the Commonwealth Director of Public Prosecutions. Relevant professional boards may also be advised in serious cases of inappropriate conduct of a health care provider.

8. Each provider should ensure they have a complete set of Notes. A 'complete' set includes both Section 1 – General information and Section 2 as follows:

Provider Type	Provider specific section
Chiropractors	Section 2(b) – Chiropractors
Clinical Psychologists	Section 2(a) – Allied Mental Health Care Providers
Dentists, Dental Specialists and Dental Prosthetists	Section 2(c) – Dentists, Dental Specialists and Dental Prosthetists
Diabetes Educators	Section 2(d) - Diabetes Educators
Dietitians	Section 2(e) – Dietitians
Exercise Physiologists	Section 2(f) – Exercise Physiologists
Neuropsychologists	Section 2(a) – Allied Mental Health Care Providers
Occupational Therapists	Section 2(g) – Occupational Therapists
Occupational Therapists – Mental Health	Section 2(a) – Allied Mental Health Care Providers
Optometrists, Orthoptists and Optical Dispensers	Section 2(h) - Optometrists, Orthoptists & Optical Dispensers
Orthotists	Section 2(n) – Orthotists
Osteopaths	Section 2(i) – Osteopaths
Physiotherapists	Section 2(j) – Physiotherapists
Podiatrists	Section 2(k) – Podiatrists
Psychologists	Section 2(a) – Allied Mental Health Care Providers
Social Workers (General)	Section 2(m) – Social Workers
Social Workers – Mental Health	Section 2(a) – Allied Mental Health Care Providers
Speech Pathologists	Section 2(l) – Speech Pathologists

Amendment of the Notes

9. The Notes may be amended from time to time by DVA, consistent with any legal obligations. Any amendments made to the Notes will be dated and DVA will undertake to ensure health care providers are made aware of the amendments to

the Notes in advance of them taking effect. This will be undertaken through consultation with representatives from your peak provider associations.

10. Notification of changes to the Notes is not sent to individual providers. It is the responsibility of each provider to ensure their set of Notes is current.

Treatment of entitled persons

Entitled persons

11. An “entitled person” means a person eligible for benefits or treatment from the Commonwealth as represented by the Commissions, in accordance with relevant legislation in the Veterans' Affairs portfolio. Entitled persons will hold a DVA Health Card issued by DVA, or have written authorisation on behalf of the Repatriation Commission or the MRCC. The DVA Health Cards entitling treatment are the Gold Card and the White Card. For more information on these Health Cards please visit https://www.dva.gov.au/health-and-treatment/veteran-healthcare-cards.

12. Entitled persons may be broadly described as:
    (a) veterans;
    (b) members and former members of the Australian Defence Force;
    (c) members of Peacekeeping Forces;
    (d) Australian mariners;
    (e) war widows and war widowers;
    (f) children and other dependants of veterans or ADF members; or
    (g) allied veterans - persons from another country who are entitled to treatment under an arrangement with another country
13. Gold Card holders are entitled to all clinically necessary treatment covered by DVA’s health care arrangements.
14. White Card holders are entitled to clinically necessary treatment for the following conditions:

(a) an 'accepted' disability, i.e. an injury or disease accepted by DVA as caused by war or service;
(b) malignant cancer (neoplasia);
(c) pulmonary tuberculosis;
(d) any mental health condition; or
(e) symptoms of unidentifiable conditions that arise within 15 years of service (other than peacetime service).

[Please note: see clause 18 for treatment of allied veterans.]

15. Health care providers must check a White Card holders' eligibility for treatment before providing treatment. If a provider is unsure of the White Card holder's eligibility, they should contact DVA for information [see clause 161 for contact details].

16. All DVA Health Cards must be current, as indicated by the expiry date, for the entitled person to be eligible for DVA funded treatment. Other cards issued by DVA, such as a Pensioner Concession Card or the Orange Card, do not entitle the person to health care services. Spouses and dependants of living entitled persons are not automatically eligible for treatment under DVA's health care arrangements.

17. Treatment can only be provided to the entitled person named on the DVA Health Card and must be provided in person unless otherwise allowed in the relevant fees schedule [see clause 129-130].

Allied veterans

18. DVA acts as an agent for certain other countries whose veterans reside in Australia. These allied veterans may hold a White Card with limited eligibility for treatment. Subject to decisions by the relevant governments of these countries, allied veterans may be treated for conditions accepted by their country as related to their war service.

19. Where allied veterans have authority to receive specified treatment, this will be provided for under DVA's health care schemes. Allied veterans are not automatically eligible for treatment for non war-caused malignant neoplasia, pulmonary tuberculosis, PTSD or mental health conditions. For further information on the eligibility of allied veterans to receive treatment under DVA arrangements, contact 1800 550 457.

Treatment thresholds/limits

20. Subject to the requirements in the Notes including the Treatment Cycle [see Clauses 24-46], the health care provider determines the type, number and frequency of the treatments to be provided to the entitled person for all of the

services that do not require prior financial authorisation from DVA. The determination must be based on the entitled person's assessed clinical needs and be part of a Patient Care Plan agreed with the entitled person, which includes the anticipated type and frequency of treatments and the goals expected of the treatment. This information must be recorded in the patient's clinical notes.[see clauses 92-95]

21. In addition to the requirements in the Notes, treatment must also be provided consistent with the fees and conditions as set out in the Schedule of Fees for the respective health care provider type [see clause 129-130].

22. The following conditions must be met for the treatment to be considered adequate and appropriate. When treating an entitled person, the health care provider will treat the entitled person according to the following:

    (a) they will be the centre of the treatment process;

    (b) they will be assessed and provided treatment, according to assessed clinical needs and best practice; and

    (c) care will be delivered in consultation with the entitled person and their usual GP [see clause 31].

23. An entitled person may ask for services that are not reasonably and clinically necessary. The Commissions do not accept financial responsibility for such services. Where it is found that such services have been paid for, the Commissions may take steps to recover payments.

Treatment Cycle

From 1 October 2019, new treatment cycle referral arrangements apply. Under these arrangements an allied health provider may treat a client for up to 12 sessions or one year, whichever ends first. At the end of the treatment cycle the allied health provider must report back to the client's usual GP. If further sessions are clinically necessary, the usual GP may provide the client with another referral for an additional 12 sessions.

Clients may have as many treatment cycles as their usual GP determines are clinically necessary. They may also have treatment cycles with multiple types of allied health providers at the same time.

In Australia's health care system, GPs are responsible for ensuring that patient care is well coordinated and that the care provided remains relevant to the clinical needs of the patient. DVA clients should see their usual GP for treatment cycle referrals.

Clients who are veterans in receipt of a Totally and Permanently Incapacitated payment (TPI veterans) will be exempt from the treatment cycle for exercise physiology and physiotherapy services. A client is identified as TPI on their DVA Gold Card. Services provided to these client must be clinically necessary.

Dental and optical services will not be affected by the treatment cycle as referrals are not needed to access these services.

Referrals for Allied Health Services

24. A referral is required for an entitled person to receive DVA funded allied health services, except for optical and dental treatment. Allied health providers must

check that the entitled person has a valid referral before undertaking any treatment.

25. A referral to an allied health service is valid for one treatment cycle which is either:
    (a) 12 sessions of treatment starting from the date of referral (which includes a consultation, treatment or assessment described within the Schedule of Fees. Diagnostic procedures, report writing, and ordering aids or equipment are excluded), or
    (b) 1 year from the date of the referral where the year ends before the entitled person has received 12 sessions of treatment.
26. Referrals for entitled persons who are in receipt of a Totally and Permanently Incapacitated payment to physiotherapists and exercise physiologists are valid for:
    (a) 12 months, or
    (b) Indefinitely, where the referral is made by the entitled person's usual general practitioner and clearly states that it is an indefinite referral for a chronic condition. Indefinite referrals must only be used where the entitled person's clinical condition is chronic and requires continuing care and management.
27. Initial referrals are valid if they are provided by:
    (a) GPs;
    (b) medical specialists; or
    (c) a health professional as part of a hospital discharge.
28. Initial referrals are made when an entitled person is assessed as requiring allied health treatment by a GP, medical specialist or by a health professional as part of a hospital discharge.
29. Only the entitled person's usual GP can determine if a referral for subsequent treatment cycle is appropriate for the entitled person.
30. The entitled person's usual GP means:
    (a) a GP who has provided the majority of care to the patient over the previous twelve months; or
    (b) a GP who will be providing the majority of care to the patient over the next twelve months; or
    (c) a GP who is located at a medical practice that provided the majority of services to the patient in the past twelve months or is likely to provide the majority of services in the next twelve months.
31. Referrals are not required to be sent with your accounts to Services Australia however, all referrals must be kept with patient records and if required, made available for auditing purposes.
32. An entitled person must not receive treatment from more than one provider of the same provider type, for the same condition at the same time.

Referral information

33. The referral must include:

(a) name and DVA file number of the entitled person (as shown on the DVA Health Card);

(b) the treatment entitlement of the person, i.e. Gold Card or White Card (include accepted conditions, if known, for White Card);

(c) provider name and provider number of the referring health care provider;

(d) confirmation that the referring provider is the entitled person's usual GP, or a medical specialist or by a health care professional as the result of a hospital discharge;

(e) date of the referral;

(f) if the entitled person is resident in a Residential Aged Care Facility (RACF), the level of care that they are funded to receive and the date the funding began;

(g) entitled person's clinical details (including recent illnesses, injuries and current medication, if applicable);

(h) the condition(s) to be treated or reason(s) for referral (and not the service to be provided e.g. Osteoarthritis of right knee not Rehabilitation); and

(i) list other treating health care providers.

34. The referral may be written using either a 'DVA Request/Referral Form' (Form D904) or using the letterhead of the referring health care provider, but must include details as set out in clause 33.

35. Should an entitled person require treatment from more than one provider of the same provider type at any point in time for different conditions, both providers will require a separate referral.

During treatment*

36. Following the first consultation, the allied health provider must prepare a written Patient Care Plan (PCP) for the entitled person. Where there is an existing PCP, it should be updated for each subsequent treatment cycle for the same condition.

37. The PCP should be revised with any changes in the entitled person's clinical circumstances.

38. Consultation fees are not payable for the ongoing maintenance of PCPs.

39. PCPs must include:

(a) provider name and number of the referring health care provider;

(b) date of the referral and date of initial consultation;

(c) condition(s) being treated or reason for referral;

(d) patient goals;

(e) the planned treatment regime, including treatment modality, the anticipated type, number and frequency of services;

(f) where relevant, list details of any aids and appliances the patient requires;

(g) the expected outcomes or results of the treatment regime for the entitled person plus proposed timelines;

(h) objective assessment results based on the use of validated outcome measurement and diagnosis of the condition(s); and

(i) a record of the entitled person's agreement to the Personal Care Plan.

40. The PCP must be consistent with all relevant professional association and national board guidelines and standards.

41. The entitled person's usual GP, as the care coordinator, may request a copy of the PCP. DVA may also request a copy of the PCP. A copy must be given pursuant to any request within seven days from the date of that request. DVA may require the allied health provider to prepare the PCP in a specific format. Where specific DVA Programs stipulate requirements for PCPs, these requirements must be met in addition to the requirements in the Notes.

42. If the entitled person's condition changes or the entitled person seeks treatment for a new condition, the health care provider may continue to provide treatment under the entitled person's current treatment cycle. For White Card holders, the new condition must be an accepted condition [See clause 14]. Allied health providers must inform the entitled person's usual GP of any changes of condition or new conditions.

**Other than optical providers, all allied health providers are required to keep patient care plans. This includes dental providers and other allied health treatment not subject to the treatment cycle. Optical providers are required to keep clinical notes as stipulated by law and/or by their association and are not required to provide this to the general practitioner.*

At the conclusion of the treatment cycle

43. DVA will not fund services provided after a referral has expired. It is the allied health provider's responsibility to monitor the number of sessions of treatment provided under the referral and the date of referral.

44. Where a referral has been made under Clause 25, the allied health provider must provide a report to the entitled persons' usual GP at the end of the treatment cycle. Where the referral is made by a medical specialist, a health professional as part of a hospital discharge or a GP who is not the patient's usual GP, the allied health provider must send the report to the referring provider and the patient's usual GP.

45. The DVA report template must be used. The report template can be downloaded from the DVA website at https://www.dva.gov.au/providers/notes-fee-schedules-and-guidelines/allied-health-treatment-cycle-and-referrals-0, and all reports must include the following information:

(a) name and DVA file number of the entitled person (as shown on the DVA Health Card);

(b) the treatment entitlement of the person, i.e. Gold Card or White Card (include accepted conditions for White Card);

(c) provider name and number of the referring health care provider;

(d) date of the referral;

(e) the number and frequency of treatment sessions provided

(f) condition being managed/reason for referral

(g) patient goals and progress made to achieve the goals

(h) summary of the treatment provided

(i) objective assessment results based on the use of validated outcome measurement and diagnosis of the condition(s);

(j) recommendation to the general practitioner on further treatment required.

46. The report can be completed:

(a) when no further treatment is required;

(b) after the provider has provided 12 sessions of treatment;

(c) 1 year from the date of the referral where that date is reached before the entitled person has received 12 sessions of treatment; or

(d) after the eighth session and before the 12th session of treatment only where the allied health provider, the entitled person and the entitled person's usual GP agree this is required to maintain continuity of allied health treatment.

Telehealth Services

47. Telehealth services may be provided by allied health providers in accordance with specific telephone and video conferencing items as listed in the relevant fee schedule. Services without a specific telehealth item number must be delivered in person.

48. Telehealth services are not intended to replace in person services and can be provided to clients who have a clinical relationship with the provider which has been established through regular in person treatment of at least one face to face appointment per year.

(a) Initial consultations cannot be delivered via telehealth and must be undertaken in person. Prior financial authorisation may be sought to deliver an initial consultation via telehealth for:

(1) children under the age of 12 months;

(2) people who are homeless;

(3) patients of an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service; or

(4) people who are in a COVID-19 Commonwealth declared hotspot, in COVID-19 isolation because of a State or Territory public health order, or in COVID-19 quarantine because of a State or Territory public health order.

(b) Extended consultations cannot be delivered via telehealth and must be undertaken in person.

(c) Exceptions to the requirements for in person consultations may be considered on a case by case basis via prior financial authorisation [see clauses 59-64]

49. Telehealth services can only be provided if the full service can be delivered safely and in accordance with all relevant professional standards and clinical guidelines. Additionally:

(a) Telephone consultations can only be provided where videoconferencing is not available.

(b) Some telehealth services are not suitable for telephone and should only be delivered by videoconference. Providers must exercise their clinical judgement to ensure any telehealth services they deliver are safe and clinically effective.

(c) Group therapy cannot be delivered by telehealth.

(d) Services requiring specialised equipment or facilities cannot be delivered by telehealth.

(e) Services requiring assessment of an entitled person's residence or site inspection of their home cannot be delivered by telehealth.

50. Telehealth services cannot be claimed for a session conducted via online chat/messaging or email.

51. Telehealth services can only be claimed where a visual or audio link has been established with the patient.

52. Telehealth services can be delivered to clients in hospital or residential aged care facilities, for services not requiring prior financial authorisation. The standard telehealth item numbers must be used for these services.

53. Telehealth services are considered a consultation under Treatment Cycle requirements except where otherwise stated.

54. Telehealth may be considered outside of these requirements on a case by case basis via prior financial authorisation [see clauses 59-64]

Transfer of care

55. If a health care provider decides to cease treating entitled persons, moves from an area, ceases practice, or if an entitled person is moving away, the health care provider must either:

(a) transfer the entitled person to another health care provider within their speciality; or

(b) advise the entitled person to contact their general practitioner for another referral.

56. Prior to transferring an entitled person, the health care provider must notify them by telephone, in person or in writing. A separate transfer is necessary for each entitled person.

57. The transfer referral will be valid for the residual time period or number of sessions remaining on the entitled person's current referral. For example, if an entitled person has four sessions remaining on a 12 session referral, the transfer should be for four sessions.

58. If the health care provider transfers to another practice location, the new practice should be the nearest suitable health care provider in that area for the entitled persons they are treating. If not, the health care provider and the entitled person will be eligible for travelling allowances equivalent to those payable to the nearest suitable health care provider.

Prior financial authorisation

59. Certain health care services require prior financial authorisation from DVA. These services are highlighted in the relevant Schedule of Fees with shading or in the case of dental treatment, listed as Schedule B [see clause 129-130]. Health care providers must contact DVA prior to administering these services to be able to claim for payment [see clause 160 for contact details].

60. A health care provider can request prior financial authorisation from DVA by forwarding a written request by mail or email on the appropriate form. Forms are available on the DVA website at https://www.dva.gov.au/about-us/forms [see clause 160 for contact details].

61. The written request for authorisation must include:

    (a) the name and DVA number of the entitled person;

    (b) the treatment entitlement of the person, i.e. Gold Card or White Card;

    (c) if the entitled person is resident in a RACF, the level of care that they are funded to receive at the date of the request;

    (d) the provider number of the requesting health care provider;

    (e) the provider number of the referrer;

    (f) the date of the referral;

    (g) the service requiring prior financial authorisation;

    (h) the costs of the treatment where appropriate; and

    (i) clinical justification for the requested service.

62. DVA will not automatically grant requests for prior financial authorisation. Each request is considered individually. Previous approval of an unrelated request for the same or another entitled person or for another health care provider does not exempt the health care provider from requesting prior approval in each circumstance.

63. Generally, DVA will not pay retrospectively for services where financial authorisation was required but not obtained unless the circumstances are exceptional. DVA reserves the right to recover monies paid to providers for services where financial authorisation was required from DVA but not obtained.

64. DVA will advise the outcome of the request to the allied health provider.

    NOTE: Dental providers should refer to Section 2(c) Notes for Dentists, Dental Specialists and Dental Prosthetists, clauses 16-19 for further details on prior financial authorisation for dental services.

Prescription of items in the Rehabilitation Appliances Program

65. Certain health care providers are recognised prescribers of selected appliances under the DVA's Rehabilitation Appliances Program (RAP). When using RAP, assessing health prescribers must forward the RAP item order form to the appropriate DVA-contracted RAP supplier.

66. Further information on RAP, including which providers are eligible to prescribe RAP items, is available on the DVA website or by contacting DVA [see clause 164

for details]. The RAP schedule of items can be found at: https://www.dva.gov.au/providers/rehabilitation-appliances-program-rap/rap-overview

Travelling assistance for entitled persons

67. DVA provides support for entitled persons to travel to attend treatment through the Repatriation Transport Scheme (RTS). Entitled persons can seek reimbursement of their travelling expenses or subject to certain criteria, may be able to access the Booked Car Scheme (BCS). You may find more information regarding the RTS at https://www.dva.gov.au/health-and-treatment/local-or-overseas-medical-care/claim-travel-expenses-under-rts

Home visits and kilometre allowance for health care providers

68. A health care provider may perform an assessment or a treatment in an entitled person's place of residence, either their home, a residential aged care facility or a hospital. There must be a genuine need to travel to see the entitled person. Examples of genuine need include where there is a requirement to conduct a home assessment or if the entitled person is physically unable to travel. If there is no evidence of a genuine need to travel, the kilometre allowance will not be paid.

69. The kilometre allowance will not be paid if;

    (a) there is no evidence of a genuine need to travel; or

    (b) you are a mobile allied health provider, without a registered street address representing your registered place of business, also referred to as your 'usual place of business'. A postal or residential address is not accepted as a registered place of business; or

    (c) there is a suitable health care provider who is located closer to the entitled person.

70. A kilometre allowance may be paid for travel from your nearest treating rooms to visit an entitled person and return. The kilometre allowance is not payable for the first ten kilometres of each journey. The kilometre allowance may be paid if:

    (a) the travel exceeds ten kilometres; and

    (b) there is no suitable health care provider who is located closer to the entitled person.

71. The kilometre allowance is claimed by writing the entire distance travelled to visit the entitled person under the heading 'kilometres travelled' on the service voucher used to claim for the service.

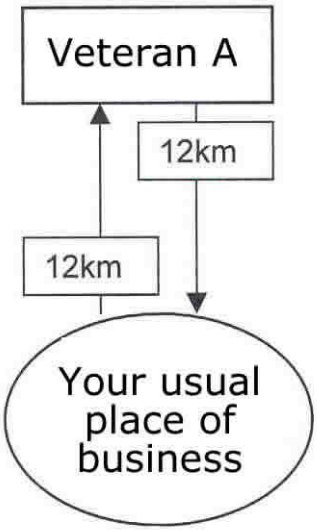
72. Different arrangements apply to Occupational Therapists providing treatment in rural and remote areas. Refer to Section 2(g) for more information.

73. When calculating the distance travelled from your 'usual place of business', you must use the distance from your closest practice address to the entitled person's place of residence. The 'usual place of business' refers to a registered place of business, with a street address and is the location where the majority of your work is conducted. A postal address is not accepted as a registered place of business.

    The following are examples of how to claim:

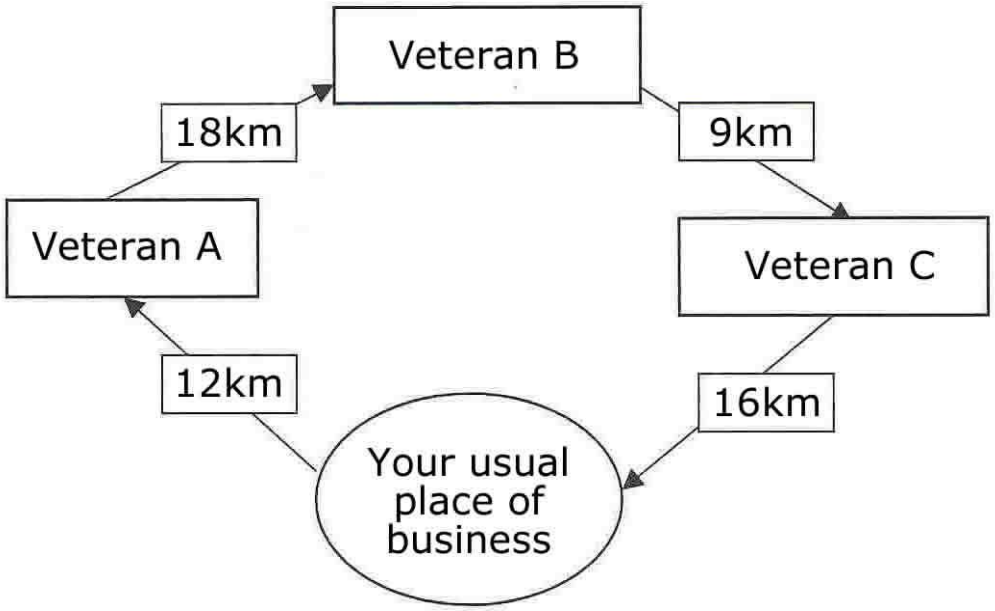
Note: For the purpose of these examples, veteran refers to entitled persons.

Example 1:



- The trip from your usual place of business to Veteran A is 12 kilometres. You return to your place of business after treating this veteran.
- Write the entire amount of the trip (24km) under 'kilometres travelled' on the claim voucher for Veteran A.
- You will be paid the kilometre allowance for 14km of this visit (the distance travelled, less the first 10km).

Example 2:



If you travel from one veteran patient to another during the day, kilometres must be claimed in components against each patient:

- The distance travelled from your usual place of business to Veteran A is 12km. Write this entire amount on the claim voucher for Veteran A. You will be paid the kilometre allowance for 2km of this trip.
- From Veteran A, you travel directly on to visit Veteran B which is a distance of 18 kilometres. Write this amount on the claim form for Veteran B. You will be paid the kilometre allowance for 8km for Veteran B.
- You then travel to Veteran C, a distance of 9km. After treating Veteran C, you return to your office, a distance of a further 16km. Write 25 kilometres (9 + 16) against Veteran C on the claim voucher. You will be paid the kilometre allowance for 15km of this journey.
- Do not claim the total trip against only one patient.
- For trips which include non-DVA patients:
  - Do not claim kilometres travelled to your non-DVA patients.
  - Kilometres are only paid for the most direct route between veteran clients.

Residential Aged Care Facilities

Note: This section does not apply to optical dispensers or dentists as they do not have access to items for RACF services.

74. The level of care an entitled person is receiving in a Residential Aged Care Facility (RACF) refers to the health status and classification of the entitled person as determined under the Classification Principles 2014.

    Note (1): a person in a RACF requiring a greater level of care is described in paragraph 7(6)(a) of the *Quality of Care Principles 2014* as a care recipient whose classification level as determined under the Classification Principles 2014 includes any of the following:

    (a) high ADL domain category;

    (b) high CHC domain category;

    (c) high behaviour domain category;

    (d) a medium domain category in at least two domains; or

    (e) a care recipient whose classification level is high level residential respite care.

75. Prior financial authorisation from DVA is required for all treatment provided to an entitled person in a RACF classified as requiring a greater level of care as described in paragraph 7(6)(a) of the *Quality of Care Principles 2014*, where it exceeds the provisions available under the *Extended Eligibility for Allied Health Treatment to Residential Care Recipients* arrangements [See clauses 82-84].

76. If you are in doubt about the classification of an entitled person in an RACF who has been referred to you, contact the facility. It is the health provider's responsibility to ascertain the assessed classification, or any changes to the assessed classification of an entitled person with the facility before treatment is provided.

77. For an entitled person residing in a RACF classified as requiring a greater level of care, as described in paragraph 7(6)(a) of the *Quality of Care Principles 2014*, the

Commissions will consider payment for short term intensive health care services required following an acute episode, such as serious illness or injury, surgery or trauma, based upon an assessed clinical need.

78. Financial authorisation is required prior to commencement of treatment and will only be approved in exceptional circumstances. Circumstances where approval may be considered include treatment to a limb following a fall and fracture or for chest physiotherapy following illness.

79. The Commissions will not accept financial responsibility for non-post acute health care services provided to an entitled person in a RACF classified as requiring a greater level of care as referred to in paragraph 7(6)(a) of the *Quality of Care Principles 2014*.

80. In some circumstances, Commissions may pay for an initial consultation to allow assessment of an entitled person's condition in circumstances where it is unclear whether the entitled person meets the above criteria.

81. For an entitled person residing in a RACF classified as requiring a lower level of care, and not described in paragraph 7(6)(a) of the *Quality of Care Principles 2014*, the Commissions will accept financial responsibility for clinically necessary health care services. Health care providers, excluding dental and optical providers must comply with referral requirements and treatment cycle requirements set out at clauses 24-46.

Extended Eligibility for allied health treatment to residential care recipients

Note: This section does not apply to dental providers, neuropsychologists, optical providers, orthotists or social workers (general).

82. For the period 10 December 2020 to 30 June 2022 (both dates inclusive) Commissions will accept financial responsibility, without prior financial authorisation, for a defined number of allied health services for an entitled person receiving residential care if the person is described in paragraph 7(6)(a) of the *Quality of Care Principles 2014*.

83. Services under these arrangements may only be claimed using the item numbers listed for this purpose in the relevant Schedule of Fees. The specified item numbers are also part of the Medicare Benefits Schedule (MBS) and the rules and requirements of the MBS apply to services provided to DVA clients. Services funded under DVA arrangements must also adhere to DVA's requirements. More detailed information can be found in the profession specific Provider Notes and/or Schedule of Fees, and at www.mbsonline.gov.au.

84. The Treatment Cycle does not apply to services under this arrangement and an End of Cycle Report item cannot be claimed in respect of these services. However, providers should familiarise themselves with the reporting requirements associated with these services and ensure they adhere to them.

DVA management requirements

Eligibility to provide DVA funded treatment

85. DVA allows health care providers who are eligible to claim for treatment services under Services Australia to provide health care services to entitled persons under DVA's statutory registration provisions without having to enter into a contract with DVA. To apply for a Services Australia provider number, register as a DVA

provider or to amend Services Australia registration details, please contact Services Australia [see clause 169 for contact details].

86. To be eligible to provide treatment under the DVA health care arrangements, a health care provider must be a registered provider with DVA at the time the service is provided. Health Care Providers are responsible for incorrect claims regardless of who does the billing or receives the benefit. Providers will be responsible for the repayment of the full amount of the incorrect DVA fee that was paid.
87. Health care providers must meet the professional and ethical standards set by the relevant professional regulatory and/or representative body. DVA requires health care providers to meet continuing education requirements set by the relevant professional regulatory and/or representative body.

Insurance and indemnity

88. State or territory laws or national provider registration bodies may require, as a condition of registration, health care providers to carry a certain level of insurance and indemnity. This may vary across provider type and jurisdiction. For health care providers covered under DVA's statutory registration scheme (i.e. registered with Services Australia), DVA does not stipulate insurance requirements or level of coverage but expects providers to hold adequate levels of insurance.
89. DVA requires that providers shall at all times indemnify and hold harmless the Commonwealth, the Commissions, their officers, employees and agents (in this paragraph referred to as "those indemnified") from and against any loss (including legal costs and expenses on a solicitor/own client basis), or liability, incurred or suffered by any of those indemnified arising from any claim suit, demand, action, or proceeding by any person against any of those indemnified where such loss or liability was caused by any wilful unlawful or negligent act or omission by yourself, your officers, employees or agents in connection with DVA's statutory registration scheme or in the course of, or incidental to, performing the health services.

Privacy

90. As a minimum requirement, health care providers must comply with the *Privacy Act 1988* in relation to the collection, storage, security, use and disclosure of the personal information of entitled persons.
91. Relevant professional boards may be advised in serious cases where the health provider has failed to deliver treatment and meet the accountability requirements as set out in the Notes. In advising the relevant professional board of non-compliance with the Notes, DVA may also disclose such information about the health provider's conduct as necessary or required by the professional board.

Record keeping requirements and provision of information

92. The health care provider must create and maintain adequate and appropriate records relating to all administrative and clinical aspects of the provision of treatment to an entitled person. The PCP and/or clinical notes must be updated in a timely manner in relation to health care services provided on a specific date of service. [For further information regarding record management see clauses 132-135 for online claiming and clauses 137-142 for paper claims.]

93. All clinical records, including assessments, PCPs, progress notes and clinical pathways, belong to the health care provider and must be retained and securely stored for the appropriate time period required under relevant State/Territory or Commonwealth legislation.

94. Health care providers must comply with any reasonable request from DVA to supply information in relation to any entitled person. Sufficient information must be provided within seven days of receiving an information request from DVA.

95. In relation to inappropriate or non-compliant claiming, the health care provider must cooperate fully with DVA in investigating the matter, and must provide all relevant information within 14 days of receiving an information request from DVA.

Electronic Communication

96. For the purpose of these Notes, and unless the contrary intention appears, DVA and a health care provider may communicate about any matter by electronic transmission e.g. email, facsimile message.

97. For clause 96, communication includes the making of a request or the provision of a notice or document.

Advertising

98. Clauses 99 to 103 apply to service providers, payee providers, people acting in an advocacy capacity for specific practice or groups of practices and any third party undertaking advertising on their behalf.

99. Advertising refers to any published printed material, websites or social media pages/posts/groups and/or physical advertising at the place of business or in public spaces that references veterans and the veteran community.

100. DVA health care providers are welcome to promote, in line with the following guidelines, that they provide allied health services to the veteran community. Please recognise that the provisions of the Health Practitioner Regulation National Law Act 2009 must be adhered to by all DVA providers. In addition to this, health care providers must not refer to DVA in any promotional material unless they observe the following conditions:

    (a) services must not be advertised as free to DVA clients. Providers must not use phrases such as, or similar to, “fully funded”, “complimentary”, “No Fees” and “DVA Pays”;
    (b) the Australian Government logo must not be used in the advertisements;
    (c) Images of DVA treatment cards (including Gold and White cards) or images with shapes and colours that resemble DVA treatment cards can only be used with the permission of DVA;
    (d) advertising must not imply endorsement as DVA’s preferred health care provider, or that the health care provider is an employee or agent of DVA;
    (e) no false or misleading information is to be included in the advertisement. This includes font size disparity where it intentionally highlights payment by another party with lesser emphasis based on clinical necessity;
    (f) advertising which refers to DVA will not be permitted if State/Territory regulations governing health practitioners prohibit advertising; and

(g) no inducements or other offers are to be made to DVA clients or their spouses.

101. Below are the only form of words providers can use, without seeking permission, to indicate the availability of allied health serves to the veteran community. Please ensure you comply with the conditions outlined above.
"We welcome DVA clients, DVA Health Cards (Gold and White) are accepted as payment upon a GP referral"
"DVA Health Cards (Gold and White) are accepted as payment upon a GP referral"
Should you wish to use an alternate form of words, approval should be sought from DVA by sending a request to HCSASSURANCE@dva.gov.au

102. You are required to meet the advertising guidelines set by your relevant professional regulatory and/or representative body.

103. If non-compliant advertising is only brought to DVA's attention after publication, the health care provider will be contacted and advised of these guidelines. Where the advertisement does not conform to these guidelines it can no longer be used and must be removed from the public space within 14 working days. If a health care provider has been informed of these guidelines and breaches them, DVA can take appropriate and necessary action which could include action under the *Competition and Consumer Act 2010*.

Use of locums, students and/or assistants

104. DVA will accept financial responsibility for the services of a locum if the locum health care provider is eligible to provide services under statutory registration and is willing to treat entitled persons under the DVA health care scheme.

105. All services provided to an entitled person must be delivered by a health care provider who is eligible to claim for these services under Medicare arrangements. DVA will not accept financial responsibility for health care services provided fully or in part to an entitled person by a student or an assistant, which is consistent with Department of Health policy. For example, if part of the service is the healthcare provider taking a case history, measuring weight, blood pressure or range of movement, demonstrating and supervising exercises or advising on self-management strategies, this needs to be undertaken by the healthcare provider and not a student or an assistant. With the consent of the entitled person, a student or an assistant may observe the service being provided by the qualified healthcare provider during a consultation funded under the DVA Schedule of Fees.

Benchmarking and monitoring and the audit process

106. DVA has systems in place to monitor the servicing and claiming patterns of health care providers. DVA uses this information, in addition to best practice guidelines from professional regulatory and/or representative bodies, to establish internal benchmarks for the delivery of services and to identify possible instances of overpayment resulting from administrative error, inappropriate-servicing or non-compliance.

107. DVA conducts audits of health care providers. The audits will examine whether a health care provider is complying with:

(a) DVA's administrative arrangements; and

(b) DVA's treatment guidelines.

108. The key objectives of the audit process are to:

(a) ensure compliance with DVA's management requirements;
(b) deliver provider education;
(c) monitor the quality of health care being provided;
(d) monitor the achievement of health care outcomes for entitled persons; and
(e) minimise the risk of overpayment as a result of administrative error, inappropriate-servicing and non-compliance.

109. The compliance audits may be conducted at the provider location, or at a DVA Office at DVA's discretion. The health care provider will be given at least 14 days advance written notification of the audit. DVA may only request clinical notes rather than interview the provider.

Inappropriate claiming

110. The Commissions reserve the right to determine the level and type of servicing for entitled persons for which it will accept financial responsibility.

111. Should it appear a health care provider may be supplying inappropriate levels or types of health care services, or has been submitting incorrect claims, DVA may contact the health care provider by telephone or in writing to discuss and clarify the Department's concerns. This may include requesting copies of patient clinical notes and other relevant documentation.

112. A reasonable period of time (not exceeding 14 days) will be given to the health care provider either to:

(a) demonstrate the health care services supplied were appropriate to meet the entitled person's treatment needs; and/or
(b) implement an agreed remedial action plan with DVA.

113. If, following a detailed response from the health care provider, DVA determines a provider's actions or behaviours to be serious breaches of these Notes, DVA may take any or all of the actions as outlined in clause 117 immediately without an agreed remediation plan being in place. DVA will write to the provider informing them of the action to be undertaken and nominating a date of effect for the determined actions.

114. DVA retains the right to recover payments made for incorrect claims or servicing not appropriately provided. Overpaid monies may be sought by Services Australia on DVA's behalf in the first instance.

Right of the Australian Government to recover money

115. Without limiting the Australian Government's rights under any provision of these Notes, the *Treatment Principles*, any other legislation or under the Common Law, any payment or debt owed by the health care provider to the Australian Government under these Notes may be recovered by the Australian Government. The Australian Government can recover the amount of payment from any claim or from any other monies payable to the health care provider for any debt owed.

116. Recovery of monies paid to health care providers by DVA can also be pursued via the civil recovery process through the Australian Government Solicitor.

117. If agreement cannot be reached on a remedial action plan, or if inappropriate servicing or claiming practices continue at variance with the said plan, DVA may:

(a) terminate your DVA provider registration and/or optical dispensers agreement (whichever is applicable);

(b) withdraw entitlement for payment for any services performed by you after the effective date of termination;

(c) recover any relevant payments made to you;

(d) disclose any relevant information to the State/Territory or national registration board and national professional association that is not restricted by any Privacy Act provisions; and

(e) Require that you notify your DVA patients of the change in your provider status and refer the DVA patient back to their general practitioner.

118. Where DVA has determined serious non-compliance exists, DVA may proceed directly to de-registration of the provider.

GST and ABNs

119. It is the health care provider's responsibility to notify Services Australia of all changes to GST registration status. Services Australia must have this information to ensure correct GST processing of claims for payment. Failure to notify Services Australia could result in failure to comply with GST law.

120. DVA requires health care providers treating entitled persons to enter into a Recipient Created Tax Invoice (RCTI) Agreement with DVA if they are registered for GST, and will be providing services to DVA (for example, reports). [See clause 166 for contact details on where to send the Agreement.]

121. The RCTI Agreement permits Services Australia to automatically add GST to claimed taxable items. It also allows Services Australia to issue the health care provider with a RCTI to comply with GST law.

122. If a health care provider does not complete DVA's RCTI Agreement, Services Australia will reject claims for payment. The RCTI Agreement is available on the DVA website [see clause 166 for details].

123. All health care providers who receive DVA payments under DVA's health care scheme are required to have an Australian Business Number (ABN). Having an ABN does not automatically mean a business is registered for GST purposes.

Financial matters

Financial responsibilities

124. The Commissions will accept financial responsibility for the provision of health care services to meet the clinically assessed needs of entitled persons. The health care services must be delivered in accordance with the Notes.

125. The Commissions will not accept financial responsibility for the cost of a service provided to an entitled person by a health care provider if, at the time the service was provided, a DVA health care benefit would not have been payable.

126. Subject to clause 11 by accepting an entitled person's Gold or White Card the health care provider agrees to accept the DVA fee as full payment for health care services without imposing any additional charges on the entitled person, unless

advised to the contrary in the Schedule of Fees [see clause 129-130], by legislation, or as described in the Notes. The Commissions' financial responsibility for health care services provided to entitled persons is limited to the fees set out in the Schedule of Fees.

127. The Commissions do not accept financial responsibility for the payment of health services appointments missed by entitled persons. If it is standard practice to charge a fee for missed appointments, the entitled person must pay that fee.

128. Services Australia undertakes the processing of DVA claims for most allied health providers. Services Australia operates a computerised claims processing system to pay health care providers who treat entitled persons. Payment can be delayed or rejected if health care providers submit claims containing incomplete, inaccurate or illegible information.

Schedule of fees

129. Payment for health care services is based on DVA's Schedule of Fees relevant to the profession and the date treatment was provided. An entitled person must first be assessed as requiring treatment and be issued a referral before seeing an allied health provider, except for dental and optical services.

130. The Schedule of Fees for each health care provider type is an integral part of these Notes. Profession specific Schedule of Fees are available on the DVA website at: https://www.dva.gov.au/providers/notes-fee-schedules-and-guidelines/fee-schedules/dental-and-allied-health-fee-schedules

Indexation of fees

131. Subject to Government policy, DVA indexes the fees for most health care providers annually.

Billing procedures – online claiming

132. Online claiming allows health care providers to submit electronic claims for processing without the need to send any paperwork to Services Australia [see clause 168].

133. Paper copies of vouchers do not need to be retained if claiming online. Health care providers must ensure that they can, from other means of record keeping, satisfy any request from Services Australia or DVA for evidence of service and details of treatment.

134. The entitled person should be provided with a record of the treatment provided.

135. When using online claiming, the health care provider must adhere to the following principles, as is required when filling out Form D1217:

(a) the services were rendered by the health care provider or on the health care provider's behalf and, to the best of the health care provider's knowledge and belief, all information in the claim is true;

(b) none of the amounts claimed are for a service which is not payable by DVA;

(c) no charge was or will be levied against an entitled person for the service, i.e. no co-payment will be requested except where allowed by DVA, and

(d) all claims for payment must be submitted within two years from the date of service.

Billing procedures – DVA Webclaim

136. DVA Webclaim is a real-time web based electronic claiming channel that allows health care providers to submit electronic claims via the internet, without the need to send any paperwork. The following should be noted when using DVA Webclaim:

(a) access to DVA Webclaim is available via the Services Australia Health Professional Online Services (HPOS) portal;

(b) Health professionals need a Medicare provider number and an individual Provider Digital Access Account (PRODA) to access DVA Webclaim;

(c) Health providers, such as entities require a Medicare provider number and a Public key Infrastructure (PKI) certificate.

All claims for payment must be submitted within two years from the date of services

For more information on DVA Webclaim, see the DVA Website provider information at https://www.dva.gov.au/providers/dva-provider-news/save-time-claim-online-dva-webclaim.

Billing procedures – manual claiming

Providers of dental services should refer to Section 2(p) Notes for Dentists, Dental Specialists and Dental Prosthetists, clauses 59 – 68 of your Notes for manual dental claims information

137. An accounts claim is made up of a 'Health Practitioner Service Voucher' (Form D1221) and a 'Claim for Treatment Services Voucher' (Form D1217). To claim for time based fees, the 'Allied Health Time Based Voucher' (Form D695) must be used.

138. For providers of optical services, an accounts claim is made up of an 'Optometric / Optical Service Voucher' (Form D1223), a 'Spectacles Prescription' (Form D931) and a 'Claim for Treatment Services Voucher' (Form D1217).

139. The health care provider sends the claim forms to Services Australia for processing. Please see clause 160 for details on where to send these claims.

140. The information below is required in the following circumstances for a claim to be considered as correctly submitted:

(a) where the patient is the holder of a DVA White Card, the name of the condition being treated (e.g. osteoarthritis), **not** the description of the treatment that was provided;

(b) for the first consultation in the referral period, the referring health care provider's name, provider number and the date of the referral; and

(c) if treatment was provided in a hospital or aged care facility, the name of that institution.

141. The process when making a paper-based claim for payment is as follows:

(a) All fields on the claim form must be completed in permanent pen before an entitled person is asked to sign;

(b) submit the original copies of D1221 and D1217 to Services Australia;

(c) give the entitled person the patient copy of the claim voucher; and

(d) keep the claimant copies of D1221 and D1217 on record.

142. For providers of optical services, the process when making a paper-based claim for payment is as follows:

(a) All fields on the claim form must be completed in permanent pen before an entitled person is asked to sign;

(b) submit the original copies of D1223, D931 and D1217 to Services Australia;

(c) give the entitled person the patient copy of D1223; and

(d) keep the claimant copies of D1223, D931 and D1217 on record.

143. Recording the patient's entitlement number exactly as it appears on their card when filling out DVA stationery minimises errors when processing accounts.

144. All health care services in an account submitted by an individual health care provider must have been rendered by the same health care provider. All health care services in an account submitted by an incorporated business entity or Government body health care provider must have been rendered at the same practice location.

145. The claim may contain service vouchers of various clients, so long as the total number is no more than 50 and contains no more than 99 services.

146. Claims for payment must be received by Services Australia within two years of the date of service delivery, however the period may be extended in special cases.

147. For health care services that require prior financial authorisation from DVA, please ensure the prior financial authorisation is granted by DVA at least one week before any associated claims are lodged with Services Australia.

Payment to different names and addresses

148. Provider numbers are location specific. The provider number used for claiming purposes must correspond to the provider number of the location at which the treatment was provided.

149. Services Australia has a group link facility, which allows payments to a name or address different from the name or address of the treating provider. When a group link is established, the payment name and address is linked to the health care provider number in the Services Australia system to ensure correct payment. To establish a group link, contact Services Australia [see clause 169 for contact details].

Non-payment of claims and resubmitting claims

Online Claims:

150. Services Australia will process online claims within two business days. It may take up to an additional two business days (if paid by Electronic Funds Transfer (EFT)) or an additional five business days (if paid by cheque) for payable benefits to be received by the provider. If your claim has not been paid within this time you should request a remittance report.

151. Remittance reports detail claims paid and rejected. Where a claim has been rejected the report will indicate the reasons for the rejection.

152. If you wish to query an online claim, contact Services Australia [see clause 162]. DVA Webclaim allows providers to download the last two years of their DVA claims history. If you wish to query about a DVA Webclaim, contact Services Australia [see clause 171].

Manual Claims:

153. Services Australia will process manual claims within 20 business days of receiving a complete and correct claim. Do not contact Services Australia with queries relating to unpaid claims until at least 25 business days after posting a manual claim. It may take up to an additional three business days for payable benefits to be received by the provider.

154. If a claim is not paid by Services Australia because of errors on the form, the entire claim or a number of service vouchers will be returned to the health care provider with an explanation of non-acceptance.

155. If an entire claim is returned, please resubmit it to Services Australia with a new Form D1217. If a single voucher or number of vouchers is declined and returned, the information needs amending. The voucher(s) can be resubmitted with the next claim.

156. If you wish to query a manual claim, contact Services Australia within two years of the date of service [see clause 167].

Adjustments

157. An adjustment may be required if an incorrect payment has been made. Requests for adjustments must be made in writing to Services Australia, and the following information must be supplied:

(a) the reason for the adjustment;
(b) the health care provider number;
(c) the claim number of the original claim; and
(d) details of the entitled person on the claim.

158. The health care provider should not submit a Form D1221 or a Form D1217 to make an adjustment.

Services DVA does not accept

159. DVA will not pay for any of the following services:

(a) services that have been paid for, wholly or partly, by Medicare or a private health insurance fund;
(b) services where the cost is otherwise recoverable, wholly or partly, by way of a legal claim;
(c) examination for employment purposes;
(d) examination for a medical certificate for membership of a friendly society;
(e) all alternative therapies including herbalist services, homeopathy, naturopathy and iridology; and
(f) massage that is not performed as part of physiotherapy, chiropractic or osteopathic services claimable through DVA and performed by a physiotherapist, chiropractor or osteopath.

Contact list

160. Health care providers can contact DVA for advice, including requests for prior financial authorisation, on the following numbers.

Phone:	1800 550 457
Email:	Health.Approval@dva.gov.au
Postal address:	GPO Box 9998 Brisbane QLD 4000

161. Entitled persons can contact DVA for general information on the following.

Phone:	1800 838 372
Email:	generalenquiries@dva.gov.au

162. Advice about prescriptions accessible under the Repatriation Pharmaceutical Benefits Schedule and approval for Authority prescriptions is available through the Veterans' Affairs Pharmaceutical Advisory Centre (VAPAC).

Phone:	1800 552 580
Fax:	(07) 3223 8651

163. To make a transport booking for an entitled person or for information about transport from the Repatriation Transport Unit, use the following numbers:

Phone:	1300 550 454 from anywhere in Australia
	1800 550 454 from non-capital city areas only

164. Information about the Rehabilitation Appliances Program (RAP) is available at:

https://www.dva.gov.au/providers/rehabilitation-appliances-program-rap/rap-overview

165. Information about DVA's community nursing program is available at:
Chttps://www.dva.gov.au/providers/health-programs-and-services-our-clients/community-nursing-services-and-providers

Phone: 1300 550 466

166. Recipient Created Tax Invoice (RCTI) Agreement:

Form available at:
https://www.dva.gov.au/providers/become-dva-health-care-provider#rcti

Enquiries:	1800 653 629
Fax form to:	1800 069 288
Email (scanned copy):	mailto: ABN.RCTI.notifications@servicesaustralia.gov.au

Mail form to:

GST Program
GPO Box 2956
ADELAIDE SA 5001

167. Claims enquiries should be directed to Services Australia:

Phone	1300 550 017

168. Written queries and completed claims for payment should be sent to:

Services Australia, Veterans' Affairs Processing
GPO Box 964
ADELAIDE SA 5001

169. Applications for provider registration, changes to address or health care provider details should be directed to Services Australia as follows:

Application forms are available at:
https://www.servicesaustralia.gov.au/organisations/health-professionals/subjects/health-professionals-starting-medicare

Changes to details and/or address:

Phone	1300 550 017

170. Online claiming

Phone	1800 700 199
Email	ebusiness@servicesaustralia.gov.au

171. Enquiries about DVA Webclaim

Phone:	1800 700 199
Email:	ebusiness@servicesaustralia.gov.au

172. Reporting Fraud

To report allegations of fraud to the Department's Business Compliance Section:

Phone	1800 838 372
Email	fraudallegation@dva.gov.au

Additional Resources

173. DVA produces a range of webpages with information for health care providers and entitled persons. To access these webpages, go to https://www.dva.gov.au/providers and use the 'Ask Pat' function to search by keyword.