Australian Government
Department of Veterans' Affairs

Community Nursing Service Voucher

- Each service voucher must be used only for services rendered by one practitioner to one patient

Manual Claiming

Mail your treatment vouchers to the appropriate address for processing:

Allied Health

National
GPO Box 964, Adelaide SA 5001

1 Complete the Patient Details section by entering the patient's file number, first name, initial and surname. If the file number is not known, include date of birth and address.
2 Complete all relevant sections.
3 Please ensure that the referral is valid as claims after the expiry date will be rejected.
4 A change in item number for the same patient requires a new referral date from the GP.
5 If the veteran is a White Card holder, the appropriate box must be ticked. If you are unsure of a White Card holder's eligibility for treatment, please contact the Department of Veterans' Affairs before providing services.
6 Nursing Services do not include shopping, cleaning, laundry, cooking, transport, companionship, etc.
7 Please submit the Departmental copy with your claim and ensure that any relevant documents are attached.
8 The Claimant copy may be retained as your record.
9 The information sought on this form is to enable service verification and claim processing. This information will be disclosed to the Department of Human Services to process the payment.

cut on this line

PATIENT DETAILS

PLEASE COMPLETE THIS FORM ONLINE AND THEN PRINT TO SIGN

FULL NAME

DATE OF BIRTH / /

ADDRESS

File number

Referrer's Provider Number

Referral Date / /

Is the veteran a WHITE card holder whose treatment is for an Accepted Disability? Yes ☐ No ☐

D1083 (0919) – Original – Department copy

Australian Government
Department of Veterans' Affairs

Community Nursing Service Voucher BZ792410

CLAIM DETAILS			
Item number(s)	No of days (for overnight care)	D.O.S./Claim period from	Discharge date/ Claim period to
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

PROVIDER DECLARATION

Nursing services have been provided to the veteran named on this voucher. All services have been provided in accordance with the departmental guidelines as required by my contract with the Department. I certify that the information provided on this document is, to the best of my knowledge, true and correct.

Signature of Authorised Person / /

Save Print Clear

cut on this line

PATIENT DETAILS

PLEASE COMPLETE THIS FORM ONLINE AND THEN PRINT TO SIGN

FULL NAME

DATE OF BIRTH / /

ADDRESS

File number

Referrer's Provider Number

Referral Date / /

Is the veteran a WHITE card holder whose treatment is for an Accepted Disability? Yes ☐ No ☐

D1083 (09/19) – Duplicate – Claimant copy

Australian Government
Department of Veterans' Affairs

Community Nursing Service Voucher BZ792410

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Item number(s)	No of days (for overnight care)	D.O.S./Claim period from	Discharge date/ Claim period to
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