Te Tira Ahu Ika A Whiro
VETERANS' AFFAIRS
New Zealand

Treatment Expenses

This form is to seek reimbursement of expenses for **treatment from a registered health practitioner for an accepted service-related injury or illness.** The accepted service-related injury or illness must be listed on your treatment card.

Veterans' Affairs (VA) may also fund urgent assessment and treatment treatment of your mental injury or illness if you have made a claim that VA has not made a decision about and VA is satisfied that a delay in the provision of treatment for the mental injury or illness until the application is decided may have an adverse effect on you. VA may also fund counselling for your spouse, partner, child, dependant, or other person who is providing non-professional support to you while you are undertaking treatment and rehabilitation. In these cases, VA will provide a letter authorizing the approved funding of the urgent treatment of your mental injury or illness and/or counselling for those persons supporting you.

Please attach the receipts for the visits to the health practitioner or for the pharmaceuticals you are claiming on this form.

Veteran Details

1	**Veterans' Affairs number (if known)**										
2	**Title**	Rank		Mr		Mrs		Ms		Other	
3	**Last name**										
4	**First name/s**										
5	**Other name/s known as**										
6	**Date of birth**	/ /									

7 Residential address

Country (if not New Zealand)	Post Code

Treatment Expenses

Date of visit	Type of expense	Disability expense is related to	Amount charged	VA use
e.g. 02/04/2015	Doctor, medicine etc	Osteoarthritis left ankle	$ 5.00	approved
		(VA staff only) Page 1 total	$	

All claims for reimbursement must be lodged no later than six months from the date of treatment or when they total more than $50.

Please attach your original receipts to this claim form. If your claim does not have a receipt, it will **not** be paid.

Treatment Expenses (continued)

Date of visit	Type of expense	Disability expense is related to	Amount charged	VA use
e.g. 02/04/2015	Doctor, medicine etc	Osteoarthritis left ankle	$ 5.00	approved
		(VA staff only) Page 2 total	$	

Declaration

This application form needs to be signed. If someone has completed this form for you, you need to make sure that you agree with what he or she has written prior to signing the form.

I declare that the expenses I have claimed are in relation to my accepted disabilities. I further declare that the information provided in this application form is, to the best of my knowledge, true and complete. I acknowledge that, as part of processing this application, Veterans' Affairs may seek to verify the information I have provided.

I am aware that under Section 270 of the Veterans' Support Act 2014 it is an offence to mislead Veterans' Affairs. Subsection (4) of this section provides that a person who commits an offence against this section is liable for prosecution for making false statements and the penalties, if found guilty, are:

(a) imprisonment for a term not exceeding 3 months: or
(b) a fine not exceeding $5,000.00.

Privacy Statement

You can read our full privacy statement on our website

Your personal information is managed in accordance with the privacy statement on our website:

- www.va.mil.nz/privacy

If you would like a copy of this posted to you please contact us:

- 0800 483 8372 from New Zealand
- +64 4 495 2070 outside New Zealand

Signature

This form must be signed either by the claimant or a person with the authority to act on the behalf of the claimant if they are unable to do so.

If the claimant didn't sign the form, **include one** of the following forms of evidence:

- Power of Attorney or Enduring power of Attorney (in relation to Property)
- Certificate of Administration (from the Public Trustee)

I acknowledge that:

- the information I have given in this claim form is true and correct
- Veterans' Affairs may obtain further information to assess and decide on my claim
- I have read and understood the Privacy Statement for Forms on www.va.mil.nz/privacy
- I authorize the collection and disclosure of health, clinical, or other personal information by or to Veterans' Affairs, held by any doctor or health practitioner or named agencies, or service providers, or contractors for the purposes set out in the privacy statement; for the purposes of assessment of this claim; administration of any resulting entitlement; and the provision of any services, treatment or rehabilitation under the Veteran's Support Act 2014.

Signature | Please sign

Claimant or authorised person

Claimant or authorised person name

Claimant or authorised person signature

D D / M M / Y Y Y Y

Helper | Complete this section if you've helped the claimant to complete this form.

Helper name

Helper's relationship to claimant

Send your completed application to:

Veterans' Affairs
PO Box 5146
WELLINGTON 6140

Office Use Only

Page 1 total $

Page 2 total $

Total to pay $

	Name	Signature	Date
Accounts officer			/ /
Issuer			/ /