



Provider Hotline Number: 1300 550 457 (metro) 1800 550 457 (country) - choose Option 1 for Aids & Appliances provided under the Rehabilitation Appliances Program (RAP).

This form is to be used for requesting items through the Rehabilitation Appliances Program. For prior approval items, please attach clinical justification or use DVA specified forms.

The provider is responsible for ensuring that the client is aware that their personal information is to be forwarded to DVA, and companies authorised by DVA to deliver products, for determining and/or providing benefits under the *Veterans' Entitlements Act 1986*. The information will be treated in a confidential manner. However, in certain circumstances it may be used for clinical review, audit or management purposes or disclosed to the client's local medical officer.

**Supplier choice:**  Aidacare  Allianz Global Assistance (Mondial)  Country Care Group  Invacare  ParaQuad

**Provider Details**

OT  RN  PT  LMO  Other (Specify Profession)

<b>Provider Stamp</b> (if applicable)	<table style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 20%;"><b>Name</b></td><td><input style="width: 80%;" type="text"/></td></tr> <tr><td><b>Provider number</b></td><td><input style="width: 80%;" type="text"/></td></tr> <tr><td><b>Employer</b></td><td><input style="width: 80%;" type="text"/></td></tr> <tr><td><b>Address</b></td><td><input style="width: 80%;" type="text"/></td></tr> <tr><td></td><td style="text-align: right;">POSTCODE</td></tr> <tr><td><b>Phone number</b></td><td>[ ] [ ] <b>Fax</b> [ ] [ ]</td></tr> <tr><td><b>Mobile number</b></td><td><input style="width: 80%;" type="text"/></td></tr> <tr><td><b>E-mail</b></td><td><input style="width: 80%;" type="text"/></td></tr> </table>	<b>Name</b>	<input style="width: 80%;" type="text"/>	<b>Provider number</b>	<input style="width: 80%;" type="text"/>	<b>Employer</b>	<input style="width: 80%;" type="text"/>	<b>Address</b>	<input style="width: 80%;" type="text"/>		POSTCODE	<b>Phone number</b>	[ ] [ ] <b>Fax</b> [ ] [ ]	<b>Mobile number</b>	<input style="width: 80%;" type="text"/>	<b>E-mail</b>	<input style="width: 80%;" type="text"/>
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<b>Phone number</b>	[ ] [ ] <b>Fax</b> [ ] [ ]																
<b>Mobile number</b>	<input style="width: 80%;" type="text"/>																
<b>E-mail</b>	<input style="width: 80%;" type="text"/>																

**Entitled Person/Delivery Details**

<b>Surname</b>	<input style="width: 75%;" type="text"/>
<b>Given name(s)</b>	<input style="width: 75%;" type="text"/>
<b>Date of birth</b>	<input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/>
<b>DVA file number</b>	<input style="width: 75%;" type="text"/>
<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Card type</b>	<input type="checkbox"/> Gold <input type="checkbox"/> White - please contact DVA to check eligibility under the client's Accepted Disability(ies). Please call <b>1300 550 457</b> (as above).
<b>Does the entitled person live in a Residential Care Facility?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes - what category of care? <input type="checkbox"/> Low 5 - 8 <input type="checkbox"/> High 1 - 4 (refer to DVA)
<b>Does the entitled person receive help under the EACH package?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes - please contact DVA
<b>Entitled person's contact phone number</b>	<input style="width: 30%;" type="text"/> [ ] [ ] <b>Alternative contact No.</b> <input style="width: 30%;" type="text"/> [ ] [ ]
<b>Residential address</b>	<input style="width: 95%;" type="text"/>
	POSTCODE
<b>Delivery address</b> (if different to above)	<input style="width: 95%;" type="text"/>
	POSTCODE

Surname

DVA File number

**Hospital Discharge Details** (Please fill out this section where equipment is related to the entitled person's discharge from hospital)

Item is required for discharge

Item is a fixture

Date of discharge

**Order Details** (Prescriber to complete)

Please refer to RAP Schedule of Equipment  
[http://www.dva.gov.au/service\\_providers/rap/Documents/RAPNatScheduleEquipment151110new.pdf](http://www.dva.gov.au/service_providers/rap/Documents/RAPNatScheduleEquipment151110new.pdf)

RAP Schedule No.	Product Catalogue No.	Size	Type	Specifications	Quantity

 For **prior approval items**, please attach clinical justification or use DVA specified forms (see RAP Schedule)

Home Owner agreement to installations (e.g. rails).

Signature   
Date

I certify that the client has been clinically assessed and that the RAP National Schedule of Equipment and RAP National Guidelines have been taken into account.

Signature   
Date



**Accounts:**  
P.O. Box 109  
Croydon, VIC, 3136  
Ph: (03) 9725 6577  
Fax: (03) 9780 5740  
Email: accounts@vhhe.com.au

**Sales / Showroom:**  
1/51 Lusher Road  
Croydon, VIC, 3136  
Ph: (03) 9725 6577  
Fax: (03) 9725 8067  
Email: sales@vhhe.com.au

**Service:**  
7/51 Lusher Road  
Croydon, VIC, 3136  
Ph: (03) 9725 6577  
Fax: (03) 9725 6522  
Email: service@vhhe.com.au



# COVER FAX FOR RAP DIRECT ORDER FORM

<b>ATTENTION:</b>	SALES	<b>FAX NUMBER:</b>	9725 8067
<b>COMPANY:</b>	VHHE/MOBILE REPAIRS	<b>NO. OF PAGES:</b>	
<b>DATE:</b>			
<b>SUBJECT:</b>			

**MESSAGE:**

FOLLOWING RAP DIRECT ORDER FORM FOR:

**Veterans Name :**

**VX NO :**

KIND REGARDS,

**THERAPISTS NAME :** .....

**PHONE NO :** .....

**EMAIL ADDRESS :** .....