Te Tira Ahu Ika A Whiro
VETERANS' AFFAIRS
New Zealand

Private Hospital Surgery

Personal Details (veteran to complete)

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

8 **Disability requiring surgery**

I would like Veterans' Affairs to consider funding the cost of surgery in a private hospital for my accepted disability of:

I confirm that this is not an accident or injury covered by ACC and that I do not have private medical insurance which would cover this surgery.

Veteran's Signature / /

Surgery Details (Specialist to complete)

9 **Surgery required**

10 **Medical practitioner identity**

HPI No. **Medical Council Registration No.**

Name

Practice Stamp (or address and telephone)

The information collected on this form will be used to make a decision on funding of private surgery only. In the collection, use and storage of information, Veterans' Affairs will, at all times, comply with the obligations of the Privacy Act 2020.

11 The need for this surgery is: ☐ Urgent ☐ Elective

12 Is the veteran on a public hospital waiting list? ☐ Yes ☐ No

If no, please provide a reason. The veteran **must** be placed on the waiting list in order for this application to be assessed.

13 Date placed on waiting list: / /

14 Name of public hospital

15 Indication of requirement for surgery

Please complete the following to indicate your evaluation of the veteran's need for surgery.

The nature and severity of the disability:
The level of pain (1-10):
The potential for harm through delay (risk to life, deterioration):
Quality of life issues (impact on family, ability to work, ability to undertake their normal recreational activity):
Estimated cost of surgery (please attach a quote with associated costs):
Any follow up and/or post operative care required e.g. physio, home help (please specify):

16 Is this the generally accepted means for treatment in New Zealand? ☐ Yes ☐ No

If no, please advise what is.

Medical Practitioner Signature ✍ / /

Please attach:
- **a copy of the hospital referral letter**
- **any relevant medical reports**
- **Itemised quote with all associated costs**

Send your completed application to:

Veterans' Affairs
PO Box 5146
WELLINGTON 6140

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