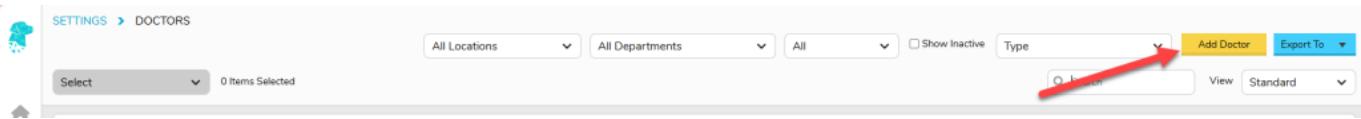


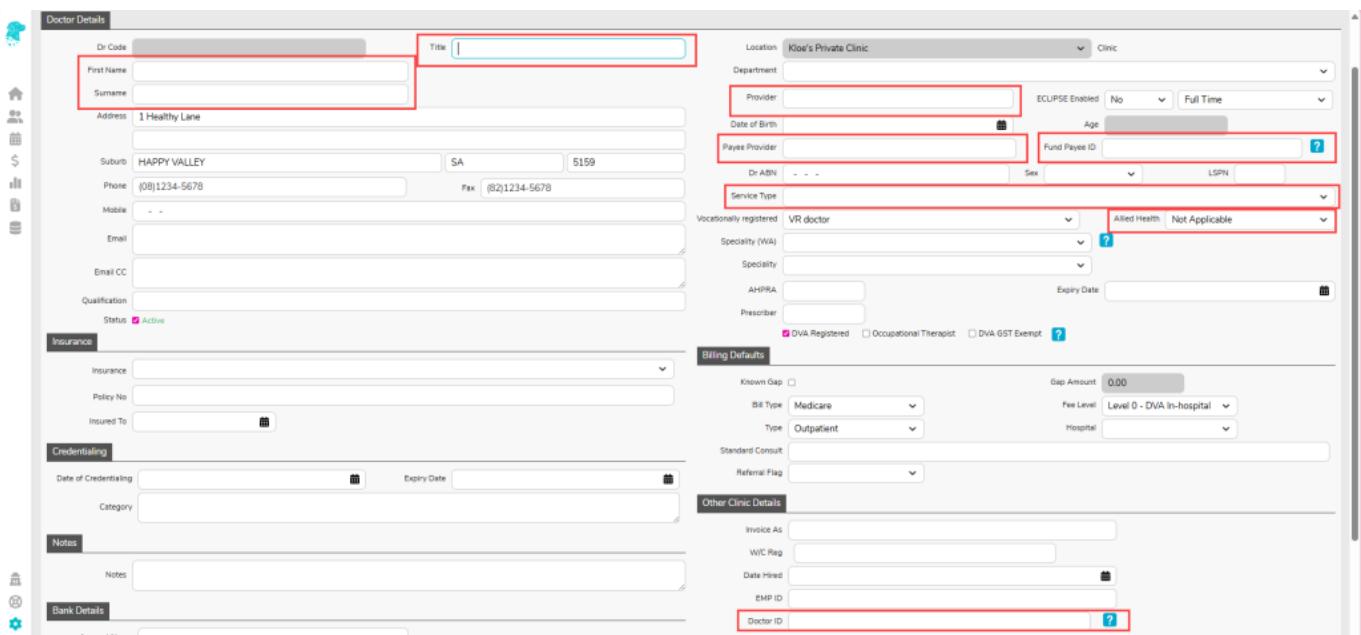
# How to Add a Doctor - Clinic

Need to add a new doctor? Or another provider number for an existing doctor? Read on to learn how!

Start off by navigating to **Settings > Doctors > Add Doctor**.



Then, add the doctor details. The key details are the doctor's name, provider number, payee provider number, fund payee ID (if applicable), service type and Allied Health (if applicable). If you are using Claims Import, you must also ensure that the Provider Number is entered in the Doctor ID field.



Once you have entered all the details, hit **Save** to create the doctor.

**Save**

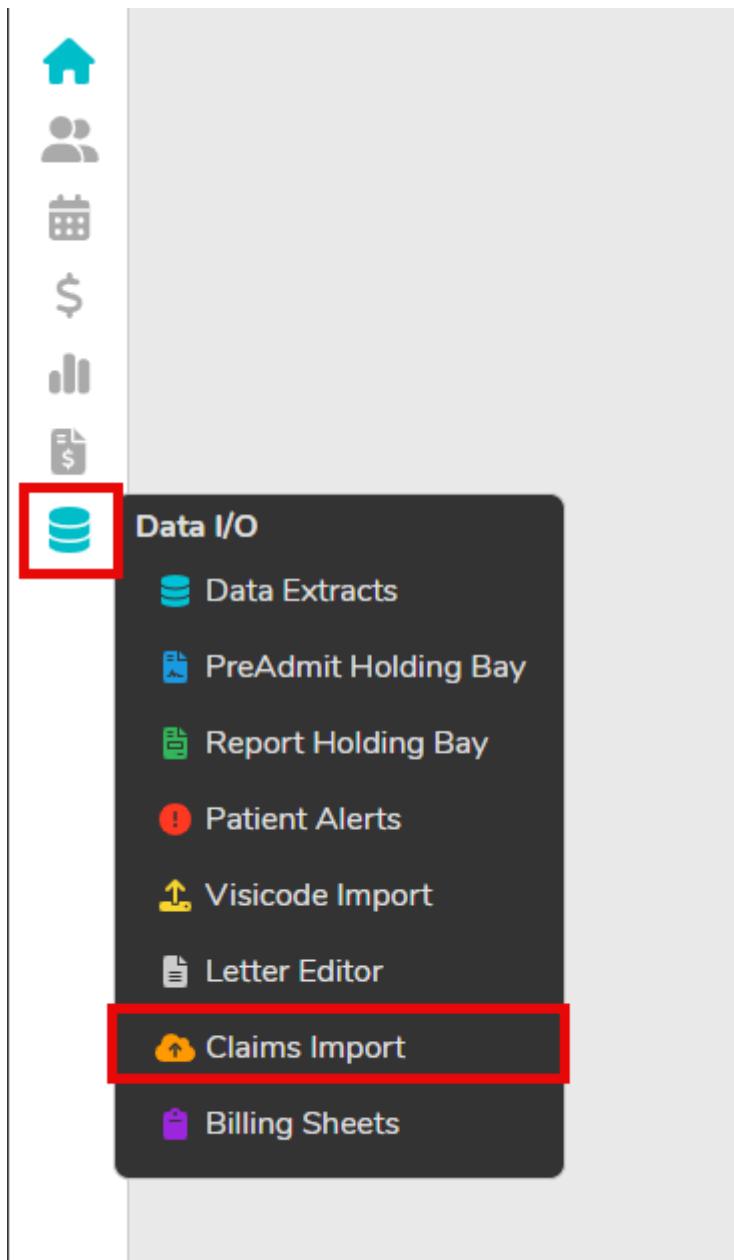
If you have more than one doctor in your FYDO account, you will need to choose the provider from the billing menu. So to set a default for a given patient, you may use the '**Preferred Doctor**' drop down from the Patients demographics screen to set a default doctor.

<b>Health Fund</b>	
Fund Name	<input type="text"/>
Membership	<input type="text"/>
Insurance Status	<input type="text"/>
Alias Name	<input type="text"/> Alias Surname <input type="text"/>
<b>Other Information</b>	
Allergies	<input type="text"/>
Family GP	<input type="text"/> Search for a Family GP
Alert	<input type="text"/>
Indigenous Sts	<input type="text"/> 
Marital Status	<input type="text"/> 
Country of Birth	<input type="text"/> 
Language	<input type="text"/> 
Employment Sts	<input type="text"/> 
Survey	<input type="text"/>   Employer <input type="text"/> Dental Benefit <input type="text"/> 0.00
O/S Visitor	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="text"/>
Interpreter	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="text"/>
Deceased	<input type="text"/>  Archived <input type="text"/> No
Location	<input type="text"/> 
Preferred Doctor	<input type="text"/> 
Bill Method	<input type="text"/>   Fee Level <input type="text"/> Level 0 - DVA In-hospital 
Send Invoices To	<input type="text"/>  

## Importing Claims

To import your claims, you will first need to make sure your file format is in compliance with our requirements. We have other wiki pages to cover this; or reach out to us at [support@alturahealth.com.au](mailto:support@alturahealth.com.au) to enquire about getting ready to import.

1. Navigate to the **Data I/O** menu via the left-hand side navigation
2. Select **Claims Import**



3. Upload your file. We have two options available for this:

- **Drag and drop** your file into the box
- Click '**Choose a file**' and navigate to the file on your local computer.

*Please note, only certain file extensions are accepted: .xml, .hinx, .xlsx and .csv*

Claims Import

Select file to upload

Drag'n drop file here  
(Click here to choose a file manually)

Choose a file

Note: Extensions allowed are:  
.xml, .hinx, .xls, .xlsx, .csv

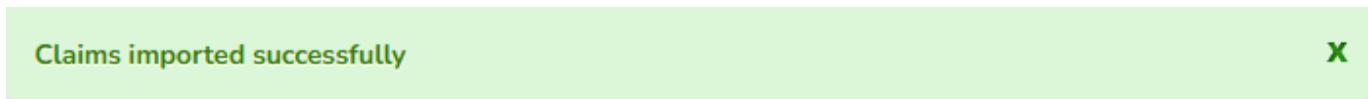
Import Cancel

#### 4. Click Import

FYDO will now attempt to process your file.

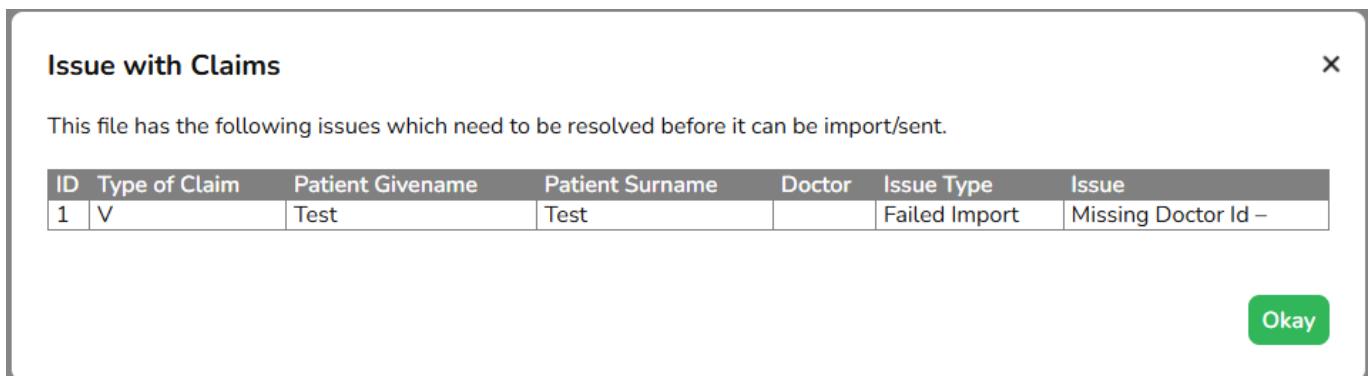


If successful, you will see the following message at the top of your screen:

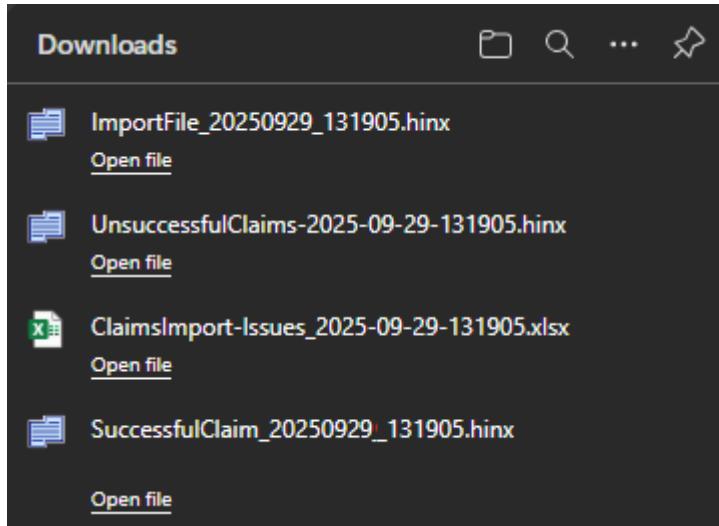


If there are issues, you will instead be met with the following message, which details which invoice(s) had issues and failed to import, as well as telling you the issue we found.

***Please note that some claims may pass, and some may fail. Any claims that pass are automatically imported into FYDO, whilst the issues are not.***



Regardless of what happens, FYDO will automatically download a few files of what has happened so you can easily follow along:



As there are a few files downloaded, we will cover them below:

- **ImportFile** - A copy of your original import in a .hinx format
- **UnsuccessfulClaims** - A .hinx copy of any claims that had issues. You will not see this if your claims were all successful
- **ClaimsImport-Issues** - A copy of any claims with issues in an .xlsx format. As above, you will not see this if all your claims were successful
- **SuccessfulClaim** - A copy of your successful claims in a .hinx format

From here, you can determine if any claims need to be amended and reimported into FYDO.

5. After you have finished importing, any IMC (Eclipse) and Patient Claims will be automatically submitted. For any other types you will need to manually send them off.

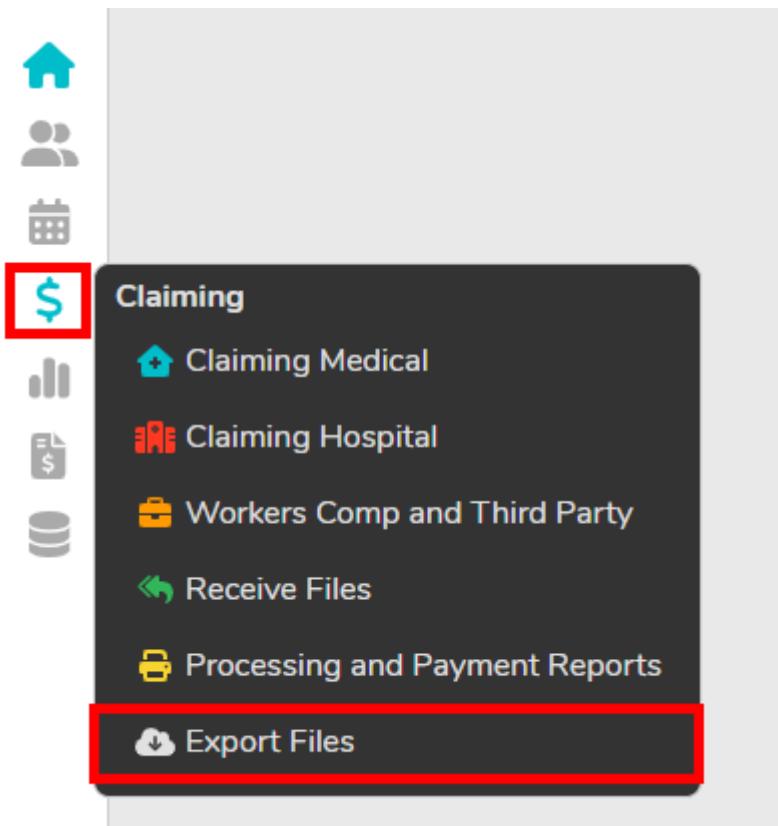
*We have a wiki page that covers the process [here](#)*

---

## Exporting Claims

FYDO has the ability to export your processing and payment information for batches as .xml files that contain all the relevant information for the claim and can be fed back into other software as needed.

1. Navigate to **Claiming** via the left-hand side navigation
2. Select **Export Files**



3. You will be met with the export screen. To actually export, you can follow these quick steps below:

- Tick as many or as few batches as desired
- From the select drop down, choose **Create Export Files**

A screenshot of the 'EXPORT FILES' screen. At the top, there are dropdown menus for 'Location' (All locations), 'Provider' (All Providers), 'Fund' (All Funds), and 'Type' (All). Below these are two dropdowns: 'Status - Export' (Pending Processing) and 'Select' (2 Items Selected). A red box with the number '1' highlights the 'Select' dropdown. A red box with the number '2' highlights the 'Create Export Files' button. Below the buttons is a table with the following data:

Type	Batch #	ID	Date ↓	Claimed	Status
<input checked="" type="checkbox"/> Medicare		432		823.30	Payment Received
<input checked="" type="checkbox"/> Medicare		657		1,017.50	Payment Received
<input type="checkbox"/> Medicare		203		297.10	Payment Received
<input type="checkbox"/> Medicare		417		411.50	Payment Received

You will be met with the final confirmation screen. Click **Yes** to generate your files

## Export Files

X

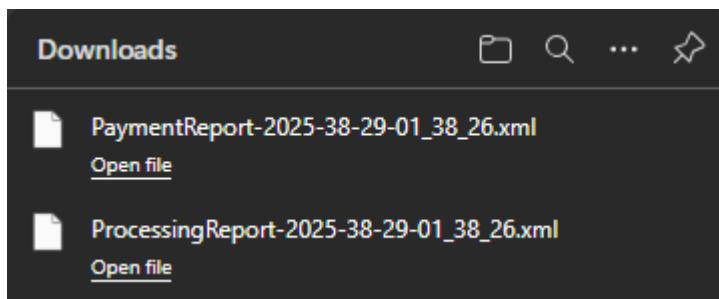
Are you sure you wish to export the Processing and Payment Files for the selected batches?

Yes

Cancel

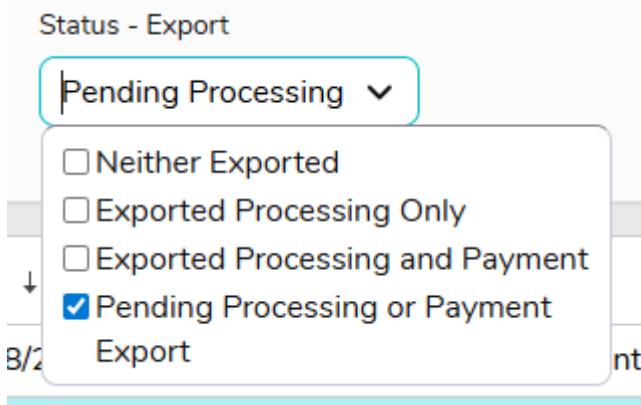
5. FYDO will then download the appropriate files. You will receive a separate file for Processing and Payment reports.

***If you are interested in the format of the returned files, we have a wiki page with detailed information [here](#)***



There is a lot of information and filters available on this page so we will cover the most important ones below:

- **Status - Export** - This is a filter that allows you to filter which batches you see on this screen. You are also able to re-export batches by selecting the appropriate filter



- **Type** - The type of claim
- **Batch #** - The batch number assigned to your claim
- **ID** - FYDO's internal ID assigned to the claim
- **Date** - The date the payment was made
- **Status** - Either Payment Received or Processed. We recommend waiting until a batch is

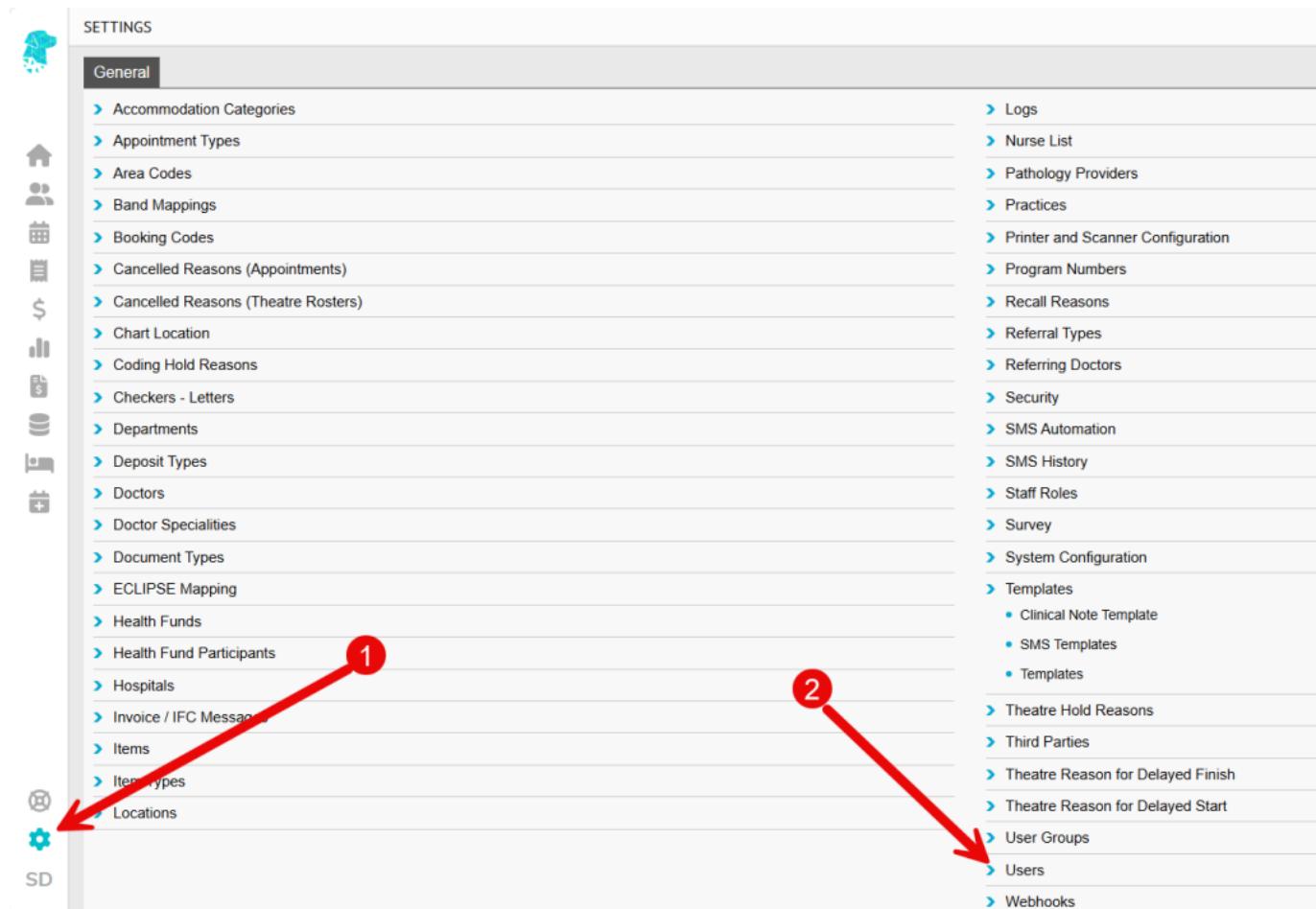
Payment Received to export it, so that you can download all relevant information at once.

- **Paid** - The amount that was paid
- **Patient and Fund** - Only applies to IMC (Eclipse Claims), provides individual patient details
- **Export** - The status of the batch. By default, you will be filtered to claims that have not been exported yet.

## Deactivating a User

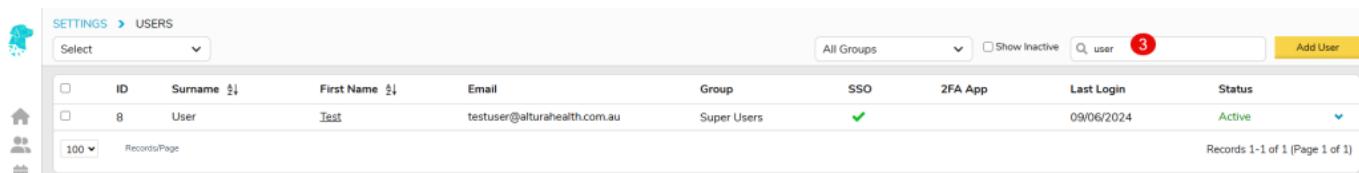
When users no longer require access to FYDO, they can be deactivated in the system.

1. Select **Settings**
2. Click **Users**



The screenshot shows the 'SETTINGS' page with the 'General' tab selected. The left sidebar contains various icons and labels for system configuration. A red arrow labeled '1' points to the 'SD' icon, which is a gear symbol. Another red arrow labeled '2' points to the 'Users' item in the list of configuration items. The list includes items such as Accommodation Categories, Appointment Types, Area Codes, Band Mappings, Booking Codes, Cancelled Reasons (Appointments), Cancelled Reasons (Theatre Rosters), Chart Location, Coding Hold Reasons, Checkers - Letters, Departments, Deposit Types, Doctors, Doctor Specialities, Document Types, ECLIPSE Mapping, Health Funds, Health Fund Participants, Hospitals, Invoice / IFC Message, Items, Item Types, Locations, Logs, Nurse List, Pathology Providers, Practices, Printer and Scanner Configuration, Program Numbers, Recall Reasons, Referral Types, Referring Doctors, Security, SMS Automation, SMS History, Staff Roles, Survey, System Configuration, Templates (with sub-points for Clinical Note Template, SMS Templates, and Templates), Theatre Hold Reasons, Third Parties, Theatre Reason for Delayed Finish, Theatre Reason for Delayed Start, User Groups, Users, and Webhooks.

3. Search for the required user and **Double Click** on their name

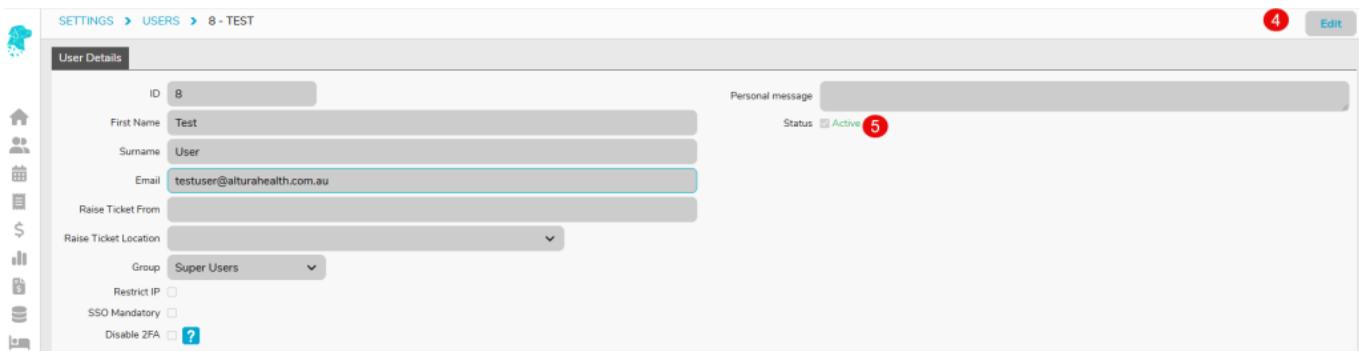


<input type="checkbox"/>	ID	Surname	First Name	Email	Group	SSO	2FA App	Last Login	Status
<input type="checkbox"/>	8	User	Test	testuser@alturahealth.com.au	Super Users	<input checked="" type="checkbox"/>	✓	09/06/2024	Active

100 Records/Page

Records 1-1 of 1 (Page 1 of 1)

4. Click **Edit**
5. Untick the **Active** box
6. Click **Save**



User Details

ID: 8

First Name: Test

Surname: User

Email: testuser@alturahealth.com.au

Raise Ticket From:

Raise Ticket Location:

Group: Super Users

Restrict IP:

SSO Mandatory:

Disable 2FA:  ?

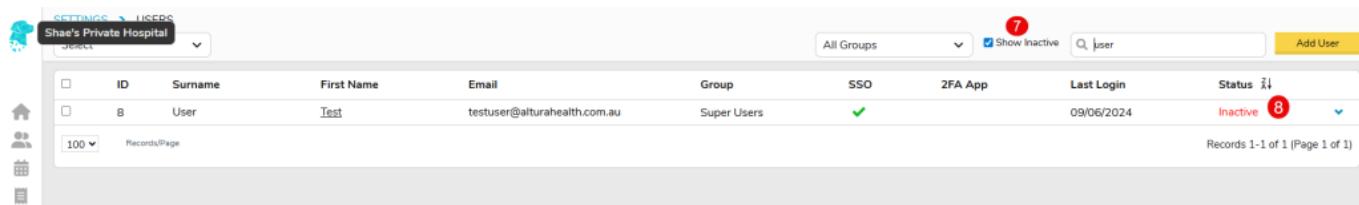
Personal message:

Status: Active 5

4

Edit

7. Inactive users can always be viewed by utilising the **Show Inactive** option
8. Inactive users will be identified with an **Inactive Status**



<input type="checkbox"/>	ID	Surname	First Name	Email	Group	SSO	2FA App	Last Login	Status
<input type="checkbox"/>	8	User	Test	testuser@alturahealth.com.au	Super Users	<input checked="" type="checkbox"/>	✓	09/06/2024	Inactive <span style="color: red;">8</span>

100 Records/Page

Records 1-1 of 1 (Page 1 of 1)

## Importing Radiology Claims - ECLIPSE

To save time double handling your radiology in-hospital claim data, import your data into FYDO and have the ECLIPSE claims paid within 4 weeks by the health funds, usually quicker.

**NOTE:** DVA in-hospital claims would go via the Medicare Online channel, not the ECLIPSE channel.

## Minimum Data Set

Everything is mandatory unless stated otherwise.

- **Patient Info**
  - External Patient ID
  - First Name
  - Middle Name (optional)
  - Last Name
  - Date of Birth
  - Gender

- Medicare Number
- Medicare Reference Number
- Health Fund Code
- Health Fund Membership Number
- Health Fund Payee ID “*also known as practice ID*” (conditional)

- **Claim Data**

- Type of Service
- Service Type Code
- External Invoice ID (optional)
- External Servicing Provider ID
- Referring Dr Details (optional)
- Referring Dr Provider Number
- Referral Date
- Referral Period (conditional)
- Request Type Code
- Referral Override Code (*conditional*)
- LSPN (Location Specific Practice Number)
- Facility Provider Number
- Benefit Assignment Authorised
- Financial Interest Disclosure Indicator
- Accident Indicator
- IFC Issue Code
- Number of Items
- Time of Service (*conditional*)
- Item
  - Date of Service
  - Charge for Item (*optional*)
  - Service Text (*conditional*)
  - Restrictive Override Code (*conditional*)
  - Duplicate Service Override Indicator (*conditional*)
  - Duplicate Service Override Text (*conditional*)
  - Paid Amount (*conditional*)

---

## Notes

## Patient Fields

**External Patient ID** - this is required so we can uniquely identify the patient. This must be unique to the patient. Every time a claim is imported, we override the patient details (e.g. first name, last name) for a patient with that same external patient id.

*Token name is: ExternalPatientId*

**Patient Name** - The first and last name is mandatory. The middle initial is not.

Tokens available:

- PatientFirstName
- PatientMiddleName
- PatientFamilyName

**Patient Gender** - patient gender.

- F = Female
- M = Male
- I = Indeterminate/Intersex
- N = Not Stated/Inadequately

*Token name is: PatientGender*

**Address** - patient address. Since this is *optional* (not required by ECLIPSE), unless you want to build your patient database in FYDO, leave the address tokens empty.

Tokens available:

- PatientAddressLine
- PatientAddressLocality
- PatientPostcode

**Health Fund** - this is the health fund the patient is with. Specify the ECLIPSE code.

*Token name is: FundBrandID*

**Health Fund Membership Number and Universal Position Indicator (UPI)** - The UPI appears on the patient's fund membership card to uniquely identify the patient. It is the number in front of the patient name on the card. The UPI is optional, but the membership number is mandatory.

*Token name is: PatientFundMembershipNum & PatientFundUPI*

**Health Fund Payee ID** - (conditional) some funds require this, also known as the Practice ID. For example, BUPA requires this. If not required, leave blank.

*Token name is: FundPayeeID*

## Invoice Fields

**External Servicing ID** - If you are billing under the one provider number, you can skip this field. If however you are billing under multiple provider numbers, then we will need something to identify which provider number to use. If you do not have the provider number, you can place your own unique code, and we will map that code to your actual provider number.

*Token name is: ExtServicingDoctor*

**External Invoice ID** - This is only required if you want to import the data back into your main system. Once claims are paid, we can send you a file back, with your external Invoice ID and Patient ID, so you can match it to the correct invoice/patient. But if you do not intend to import the data back, then you can skip this field.

*Token name is: ExternalInvoice*

**Type of Service** - this sets the type of claim for ECLIPSE. Always set to N.

- N - Inpatient/ In-hospital

*Token name is: TypeOfService*

**Service Type Code** - this sets the service type, i.e. General or Specialist or Pathology, for example

- S - Specialist

*Token name is: ServiceTypeCde*

**Location Specific Practice Number** - code provided to each practice.

*Token name = LSPNum*

**Facility Provider Number** - the provider number of the facility where the service was rendered.

*Token name is: FacilityId*

**Benefit Assignment Authorised** - Indicates that the patient has authorised the assignment of their rights of benefit to a provider. Always indicate authorised.

*Required when 'Type of Service' is M or V, not required when Service Type = P. If set to N, the claim will not import.*

- Y - Authorised

*Token name = BenefitAssignmentAuthorised*

**Charge [for each Item]** - you do not need to provide any amounts as FYDO can work out the amount when we import the data. If, however, you are not charging the Medicare/DVA rate, then you will need to provide the charge amount for each item.

*Token name = ChargeAmount*

**Number of Items** - this is like a checker that confirms how many items we should be expecting within the claim/invoice.

*Token name = NumberItems*

**Fee List (Optional)** - If you are manually setting up item fees within FYDO, you can specify which fee level number should be applied by including it in the import file. Please note that if you choose this option, instead of including the charge for each item in the file, you will need to manually update the fees within FYDO whenever there is an increase to your private fees.

*Token name is: feelist*

## Referral Fields

**Referring Dr Title / First name / Last name** - these are optional, but we would recommend including it in the file. But not a deal breaker.

*Tokens available:*

- *RefDrFirstName*
- *RefDrLastName*
- *RefDrTitle*
- *RefDrAddress*
- *RefDrSuburb*
- *RefDrState*
- *RefDrPostcode*
- *RefDrPhone*
- *RefDrfax*
- *RefDrEmail*

**Referring Provider Number** - provider number of the referring doctor.

*Token name is: ReferringProviderNum*

**Referral Date** - Date of the referral.

Format dd/mm/yyyy

*Token name is: ReferralIssueDate*

**Referral Period** - The number of months the referral is valid for. Format is numeric up to 2 digits.

- 3
- 12

- 99 (Indefinite)

*Token name is: ReferralPeriod*

**Request Type Code** - Type of referral. For radiology, set this to:

D - Diagnostic

*Token name is: RequestTypeCde*

**Referral Override Type Code** - Indicates why referral services were provided without referral from another practitioner. This is only required if you do not add referral information.

- L - Lost
- E - Emergency
- H - Hospital
- N - Not required (non referred)
- R - remote Exemption (DVA Only)

*Token name: ReferralOverrideTypeCde*

## IMC Specific Fields

**Financial Interest Disclosure Indicator** - Indicates that the provider providing the hospital treatment under a gap cover scheme has disclosed to the patient any financial interest in any products or services recommended or given to the patient.

*Must be set to Y if the **Claim Type Code** is set to SC*

- Y = Financial Interest Disclosed
- N = No Financial Interest Disclosed

*Token name is: FinancialInterestDisclosureInd*

**Accident Indicator** - Indicates whether or not the associated information relates to the patient experiencing an accident.

- Y - Service result of an accident
- N - Service not a result of an accident or unknown

*Token name is: AccidentInd*

**Compensation Claim Indicator** - Indicates whether or not the invoice is subject to a compensation claim.

- Y - Claim maybe a part of compensation
- N - Claim is not part of compensation

*Token name is: CompensationClaimInd*

**IFC Issue Code** - indicates if an Informed Financial Consent (IFC) was provided to the patient prior to the episode of care.

*If the **Claim Type Code** is set to SC, then this must be either: W or X.*

*If the **Claim Type Code** is set to AG, then this must be either: V, W or X*

- V = Verbal
- W = In writing, where appropriate
- N = Not issued
- X = Not obtained

*Token name is: IFCIssueCde*

## Fields related to the Item

**Restrictive Override Code** - Indicator used to allow payment for service where the account provides indication that the service is not restrictive with another service either within the same claim or on the patient history.

- SP - Separate Sites
- NR - Not Related (Care Plans)
- NC - Not for comparison

Note, this can not be set if the Service Type Code = P

*Token name: RestrictiveOverrideInd*

**Duplicate Service Override Indicator** - indicates if the practitioner attended the patient on more than one occasion on the same day.

- Y - Not Duplicate
- N - Duplicate

Note, this can not be set if Service Type Code = P

*Token name: DuplicateServiceOverrideInd*

**Time of Service** - The time the service was rendered. This field is conditional.

Format HH:MM, expressed in 24-hour time, e.g. 14:35 for 2:35 pm.

This field must be set if any of 'Duplicate Service Override' Indicator, 'Multiple Procedure Override Indicator' or 'Rule 3 Exemption' is set to Y.

*Token name is: TimeOfService*

**Service Text** - Free text used to provide additional information to assist with the benefit assessment of the service. Only used when absolutely required, as text will mean the claim will need to be manually assessed, which delays the processing.

*Token name = ServiceText*

**Paid Amount** - This field is conditional. Field used to indicate how much a patient has paid for an item. If it matches the total amount for the item, the claim will be marked as Paid in Full

*Token name = PaidAmount*

## **Other tokens that might be required**

**Claimant Details** - provide this if the claimant is other than the patient. If required, then the following is mandatory: First name, Surname, Medicare Number, Medicare Reference Number, Date of Birth. An example of when this is required is when the patient is a child under 18 years of age.

The address is not required. It is only required if you need to indicate a temporary address. The address cannot be a PO BOX.

*Tokens available:*

- *ClaimantFamilyName*
- *ClaimantFirstName*
- *ClaimantDateOfBirth*
- *ClaimantMedicareCardNum*
- *ClaimantReferenceNum*
- *ClaimantAddressLine1*
- *ClaimantAddressLine1*
- *ClaimantAddressLocality*
- *ClaimantAddressPostcode*

---

## **Returned Files that can be imported back into your system**

This is an optional step, and is useful provided your main system can import files.

Read more at [Claims Import - Returned Files - FYDO Wiki](#)

---

## **Sample Files**

---

# **Importing Pathology Claims - ECLIPSE**

To save time double handling your pathology claim data, import your data into FYDO and have the ECLIPSE claims paid within 4-5 weeks by the health funds.

**NOTE:** DVA in-hospital claims would go via the Medicare Online channel, not the ECLIPSE channel.

## **Minimum Data Set**

Everything is mandatory unless stated otherwise.

- **Patient Info**

- External Patient ID
- First Name
- Middle Initial (optional)
- Last Name
- Date of Birth
- Gender
- Medicare Number
- Medicare Reference Number
- Health Fund Code
- Health Fund Membership Number
- Health Fund Payee ID *“also known as practice ID”* (conditional)

- **Claim Data**

- Type of Service
- Service Type Code
- External Invoice ID (optional)
- External Servicing Provider ID
- Referring Dr Details (optional)
- Referring Dr Provider Number
- Referral Date
- Specimen Collection Point (SCP)
- Facility Provider Number
- Benefit Assignment Authorised
- Financial Interest Disclosure Indicator
- Accident Indicator
- Account Paid Indicator
- IFC Issue Code
- Number of Items
- Time of Service (conditional)
- Item
  - Date of Service
  - Rule 3 Exempt Indicator

- S4B3 Exempt Indicator
- Accession Date and Time (conditional)
- Collection Date and Time (conditional)
- Charge for Item (optional)
- Service Text (conditional)

---

## Notes

**Patient Name** - The first and last name are mandatory. The middle initial is not.

Tokens available:

- PatientFirstName
- PatientSecondInitial
- PatientFamilyName

**Patient Gender** - patient gender.

- F = Female
- M = Male
- I = Indeterminate/Intersex
- N = Not Stated/Inadequately

*Token name is: PatientGender*

**Address** - patient address. Since this is *optional* (not required by the ECLIPSE), unless you want to build your patient database in FYDO, leave the address tokens empty.

*Tokens available:*

- PatientAddressLine
- PatientAddressLocality
- PatientPostcode

**Health Fund** - this is the health fund the patient is with, specific the ECLIPSE code.

*Token name is: FundBrandID*

**Health Fund Membership Number and Universal Position Indicator (UPI)** - The UPI appears on the patient's fund membership card to uniquely identify the patient. It is the number in front of the patient name on the card. The UPI is optional, but the membership number is mandatory.

*Token name is: PatientFundMembershipNum & PatientFundUPI*

**Health Fund Payee ID** - (conditional) some funds require this, also known as the Practice ID. For example, BUPA and Medibank Private requires this. If not required, leave blank.

*Token name is: FundPayeeID*

**External Patient ID** - this is required so we can uniquely identify the patient. This must be unique to the patient. Everytime a claim is imported, we override the patient details (e.g. first name, last name) for a patient with that same external patient id.

*Token name is: ExternalPatientId*

**External Servicing ID** - If you are billing under the one provider number, you can skip this field. If however you are billing under multiple provider numbers then we will need something to identify which provider number to use. You do not have to provider the actual provider number, you can place your own unique code, and we will map that code to your actual provider number.

*Token name is: ExtServicingDoctor*

**External Invoice ID** - This is only required if you want to import the data back into your main system. Once claims are paid, we can send you a file back, with your external Invoice ID and Patient ID, so you can match it to the correct invoice/patient. But if you do not intend to import the data back, then you can skip this field.

*Token name is: ExternalInvoice*

**Type of Service** - this sets the type of claim for ECLIPSE. Always set to N.

- N - Inpatient/ In-hospital..

*Token name is: TypeOfService*

**Service Type Code** - this sets the service type, i.e. General or Specialist or Pathology, for example

- P - Pathology

*Token name is: ServiceTypeCde*

**Referring Dr Title / First name / Last name** - these are optional, but we would recommend including it in the file. But not a deal breaker.

*Tokens available:*

- *RefDrFirstName*
- *RefDrLastName*
- *RefDrTitle*
- *RefDrAddress*
- *RefDrSuburb*
- *RefDrState*
- *RefDrPostcode*
- *RefDrPhone*
- *RefDrFax*
- *RefDrEmail*

**Referring Provider Number** - provider number of the referring doctor.

*Token name is: ReferringProviderNum*

**Referral Date** - Date of the referral.

Format dd/mm/yyyy

*Token name is: ReferralIssueDate*

**Referral Period** - This is the Referral Period in months. This should be set to either 3 (Specialist), 12 (GP) or 99 (Indefinite)

*Token name is: ReferralPeriod*

**Specimen Collection Point** - code provided to each pathology lab.

*Token name = SCPId*

**Facility Provider Number** - the provider number of the facility where the service was rendered.

*Token name is: FacilityId*

**Benefit Assignment Authorised** - Indicates that the patient has authorised the assignment of their rights of benefit to a provider. Always indicate authorised.

*Required when 'Type of Service' is M or V, not required when Service Type = P. If set to N, the claim will not import.*

- Y - Authorised

*Token name = BenefitAssignmentAuthorised*

**Financial Interest Disclosure Indicator** - Indicates that the provider providing the hospital treatment under a gap cover scheme has disclosed to the patient any financial interest in any products or services recommended or given to the patient.

*Must be set to Y if the **Claim Type Code** is set to SC*

- Y = Financial Interest Disclosed
- N = No Financial Interest Disclosed

*Token name is: FinancialInterestDisclosureInd*

**Accident Indicator** - Indicates whether or not the associated information relates to the patient experiencing an accident.

- Y - Service result of an accident
- N - Service not a result of an accident or unknown

*Token name is: AccidentInd*

**Account Paid Indicator** - Indicates whether or not an account has been paid in full.

*Token name = AccountPaidInd*

**IFC Issue Code** - indicates if an Informed Financial Consent (IFC) was provided to the patient prior to the episode of care.

*If the **Claim Type Code** is set to SC, then this must be either: W or X.*

*If the **Claim Type Code** is set to AG, then this must be either: V, W or X*

- V = Verbal
- W = In writing, where appropriate
- N = Not issued
- X = Not obtained

*Token name is: IFCIssueCde*

**Charge [for each Item]** - you do not need to provide any amounts as FYDO can work out the amount when we import the data. If however, you are not charging the Medicare/DVA rate, then you will need to provide the charge amount for each item.

*Token name = ChargeAmount*

**Fee List (Optional)** - If you are manually setting up item fees within FYDO, you can specify which fee level number should be applied by including it in the import file. Please note that if you choose this option, instead of including the charge for each item in the file, you will need to manually update the fees within FYDO whenever there is an increase to your private fees.

*Token name is: feelist*

**Number of Items** - this is like a checker that confirms how many items we should be expecting within the claim/invoice.

*Token name = NumberItems*

**Rule 3 Exempt Indicator** - used to indicate Rule 3 in the Medicare Benefits Schedule applies to the pathology service and indicates the patient had multiple pathology tests with a 24 hr period due to a chronic illness, resulting in a higher rate.

*Token name = Rule3ExemptInd*

*If set to Yes, the 'Time Of Service' must be set and 'S4B3 Exempt Indicator' cant be set to Y.*

**S4B3 Exempt Indicator** - Flags the associated service as requiring assessing in accordance with S4B3 requirements of the MBS.

- Y - Exempt
- N - Not Exempt

*Token name = S4B3ExemptInd*

*If set to Yes, then must set 'Accession Date and Time' as well as the 'Collection Date and Time'. All services for the same patient for a 24 hr period should contain both 'Accession Date and Time' as well as the 'Collection Date and Time'.*

**Collection Date and Time** - This is the date and time the actual pathology sample was taken/extracted from the patient whether this be blood, tissue or a spontaneous ejection.

Format DDMMYYYYHHMM e.g. 300620161330

*Token name = CollectionDateTime*

**Accession Date and Time** - This is the date and time when the pathology test was actually performed.

Format DDMMYYYYHHMM e.g. 300620161330

*Token name = AccessionDateTime*

**Time of Service** - The time the service was rendered. Format HHMM, expressed in 24 hours time e.g. 1435 for 2:35 pm. This is only required sometimes. Please read above when required.

*Token name is: TimeOfService*

**Service Text** - Free text used to provide additional information to assist with the benefit assessment of the service. Only used when absolutely required, as text will mean the claim will need to be manually assessed, which delays the processing.

*Token name = ServiceText*

Limited to 100 characters for Veterans claims, otherwise limited to 50 characters.

## **Other tokens that might be required**

**Claimant Details** - provide this if the claimant is other than the patient. If required, then the following is mandatory: First name, Surname, Medicare Number, Medicare Reference Number, Date

of Birth. An example of when this is required is when the patient is a child under 18 years of age.

The address is not required. It is only required if you need to indicate a temporary address. The address cannot be a PO BOX.

*Tokens available:*

- *ClaimantFamilyName*
- *ClaimantFirstName*
- *ClaimantDateOfBirth*
- *ClaimantMedicareCardNum*
- *ClaimantReferenceNum*
- *ClaimantAddressLine1*
- *ClaimantAddressLine1*
- *ClaimantAddressLocality*
- *ClaimantAddressPostcode*

---

## Returned Files that can be imported back into your system

This is an optional step and is useful provided your main system can import files.

Read more at [Claims Import - Returned Files - FYDO Wiki](#)

---

## Sample Files

---

## Importing Specialist Claims - Eclipse

To save time double handling your specialist claim data, import your data into FYDO and have the ECLIPSE claims paid within 4 weeks by the health funds.

**NOTE:** DVA in-hospital claims would go via the Medicare Online channel, not the ECLIPSE channel.

---

## Minimum Data Set

Everything is mandatory unless stated otherwise.

### Patient Information

- External Patient ID
- First Name
- Middle Initial (optional)
- Last name
- Date of Birth
- Gender
- Address (optional)
- Medicare Number or Veterans Affairs Number
- Medicare Reference Number (conditional)
- Health Fund Code
- Health Fund Membership Number
- Health Fund Universal Position Identifier (optional)
- Health Fund Payee ID *“also known as practice ID”* (conditional)

## Claim Data

- External Invoice ID (optional)
- External Servicing Provider ID
- Type of Service
- Service Type Code
- Financial Interest Disclosure Indicator
- Accident Indicator
- IFC Issue Code
- Benefit Assignment Authorised
- Facility Provider Number
- Referring Dr Details (optional)
- Referring Dr Provider Number
- Referral Date
- Referral Period Type
- Referral Period (conditional)
- Number of Items
- Item
  - Date of Service
  - Charge [for each item] (conditional)
  - Service Text (conditional)
  - Time of Service (conditional)
  - Number of Patients Seen (conditional)
  - Self Deemed
  - Multiple Procedure Override
  - Duplicate Service Override

## Notes

**External Patient ID** - this is required so we can uniquely identify the patient. This must be unique to the patient. Everytime a claim is imported, we override the patient details (e.g. first name, last name) for a patient with that same external patient id.

*Token name is: ExternalPatientID*

**Gender** - patient gender.

- F = Female
- M = Male
- I = Indeterminate/Intersex
- N = Not Stated/Inadequately

*Token name is: PatientGender*

**Address** - patient address. Since this is *optional* (not required by the ECLIPSE), unless you want to build your patient database in Fydo, leave the address tokens empty.

*Tokens available:*

- *PatientAddressLine*
- *PatientAddressLocality*
- *PatientPostcode*

**Health Fund Universal Position Indicator (UPI)** - The UPI appears on the patient's fund membership card to uniquely identify the patient. It is the number in front of the patient name on the card.

*Token name is: PatientFundUPI*

**Health Fund Brand ID** - this is the health fund ECLIPSE code.

*Token name is: FundBrandID*

**Health Fund Payee ID** - (conditional) some funds require this. Also known as the Practice ID. For example, BUPA and Medibank Private requires this. If not required, leave blank.

*Token name is: FundPayeeID*

**External Invoice ID** - This is only required if you want to import the data back into your main system. Once claims are paid, we can send you a file back, with your external Invoice ID and Patient ID, so you can match it to the correct invoice/patient. But if you do not intend to import the data back, then you can skip this field.

*Token name is: ExternalInvoice*

**External Servicing ID** - Put the doctors provider number here, or a unique code to identify the doctor, and we can map it to the correct provider number.

*Token name is: ExtServicingDoctor*

**Type of Service** - this sets the type of claim for ECLIPSE. Always set to N.

- N - Inpatient/ In-hospital

*Token name is: TypeOfService*

**Service Type Code** - this sets the service type. Always set to S.

- S - Specialist

*Token name is: ServiceTypeCde*

**Financial Interest Disclosure Indicator** - Indicates that the provider providing the hospital treatment under a gap cover scheme has disclosed to the patient any financial interest in any products or services recommended or given to the patient.

*Must be set to Y if the **Claim Type Code** is set to SC*

- Y = Financial Interest Disclosed
- N = No Financial Interest Disclosed

*Token name is: FinancialInterestDisclosureInd*

**Accident Indicator** - Indicates whether or not the associated information relates to the patient experiencing an accident.

- Y - Service result of an accident
- N - Service not a result of an accident or unknown

*Token name is: AccidentInd*

**IFC Issue Code** - indicates if an Informed Financial Consent (IFC) was provided to the patient prior to the episode of care.

*If the **Claim Type Code** is set to SC, then this must be either: W or X.*

*If the **Claim Type Code** is set to AG, then this must be either: V, W or X*

- V = Verbal
- W = In writing, where appropriate

- N = Not issued
- X = Not obtained

*Token name is: IFCIssueCde*

**Benefit Assignment Authorised** - indicates if the claim will go through the ECLIPSE channel or whether a paper based claim will be created that will need to be manually delivered to the health fund.

- Y = Yes, submit through ECLIPSE
- N = No, create paper based invoice addressed to the health fund

*Token name is: BenefitAssignmentAuthorised*

**Facility Provider Number** - the provider number of the facility where the service was rendered.

*Token name is: FacilityId*

**Referring Dr Title / First name / Last name** - these are optional, but we would recommend including it in the file, at least the referring doctors first and last name, but not a deal breaker. However, the provider number is mandatory. You can pass other information (but not essential) such as the referring doctor's address, contact numbers and email address.

*Tokens available:*

- *RefDrFirstName*
- *RefDrLastname*
- *RefDrTitle*
- *RefDrAddress*
- *RefDrSuburb*
- *RefDrState*
- *RefDrPostcode*
- *RefDrPhone*
- *RefDrfax*
- *RefDrEmail*

**Referring Doctor Provider Number** - this is mandatory, whilst the referring doctors demographics are optional.

*Token name is: ReferringProviderNum*

**Referral Date** - format is dd/mm/yyyy

*Token name is: ReferralIssueDate*

**Referral Period** - This is the Referral Period in months. This should be set to either 3 (Specialist), 12 (GP) or 99 (Indefinite)

*Token name is: ReferralPeriod*

**Number of Items** - this is a checker that confirms how many items we should be expecting within the invoice / claim.

*Token name is: NumberItems*

**Charge [for each Item]** - Conditional. This is the amount charged for the specific item. If you cannot pass this information, then we can setup fees in Fydo.

*Token name is: ChargeAmount*

**Fee List (Optional)** - If you are manually setting up item fees within FYDO, you can specify which fee level number should be applied by including it in the import file. Please note that if you choose this option, instead of including the charge for each item in the file, you will need to manually update the fees within FYDO whenever there is an increase to your private fees.

*Token name is: feelist*

**Self Deemed** - A Self Deemed service is a service provided by a consultant physician or specialist as an additional service to a valid request. A substituted service is a service provided that has replaced the original service requested.

- SD - Self Deemed
- SS - Substituted Service
- N - Not Self Deemed

*Token name is: SelfDeemedCde*

**Multiple Procedure Override Indicator** - Indicates whether the service is part of a multiple procedure or not. For example, if you have to bill an item twice because it was performed on the left and right leg.

*If set to Y, then the reason for the override must be included in the **Service Text**.*

- Y - Not Multiple
- N - Multiple

*Token name is: MultipleProcedureOverrideInd*

**Duplicate Service Override Indicator** - Indicates if the servicing dr attended the patient on more than one occasion on the same day.

- Y - Not Duplicate
- N - Duplicate

If Y, then you will need to add some service text (at the item level) or set the **Time of Service** field.

*Token name is: DuplicateServiceOverrideInd*

**Number of Patients Seen** - The number of patients seen. Must be set for group attendance items (e.g. counselling) or visits (home, hospital or institution) to ensure the correct payment is made. Range is 1-99, otherwise this field is not applicable.

*Token name is: NoOfPatientsSeen*

**Time of Service** - The time the service was rendered. Format HHMM, expressed in 24 hours time e.g. 1435 for 2:35 pm.

*Token name is: TimeOfService*

**Service Text** - Free text used to provide additional information to assist with the benefit assessment of the service.

Only used when absolutely required, as text will mean the claim will need to be manually assessed, which delays the processing time of your claim. Limited to 50 characters.

*Token name is: ServiceText*

---

## **Returned Files that can be imported back into your system**

This is an optional step and is useful provided your main system can import files.

Read more at [Claims Import - Returned Files - FYDO Wiki](#)

---

## **Sample Files**

---

## **Importing Specialist Claims - Medicare / DVA / Patient Claims**

To save time double handling your specialist claim data, import your data into FYDO and have the claims paid within 1-3 working days for Medicare and DVA claims.

---

# Minimum Data Set

Everything is mandatory unless stated otherwise.

- **Patient Info**

- External Patient ID
- First Name
- Middle Initial (optional)
- Last name
- Date of Birth
- Gender
- Veterans Affairs Number (conditional)
- Medicare Number (conditional)
- Medicare Reference Number (conditional)
- Claimant Details (conditional - *required for Patient Claims only*)
- Bank Account Details (conditional - *required for Patient Claims only*)

- **Claim Data**

- Type of Service
- Service Type Code
- External Invoice ID (*optional*)
- External Servicing Provider ID
- Date Of Service
- Time of Service (*conditional*)
- Referring Dr Title (*optional*)
- Referring Dr First name (*optional*)
- Referring Dr Last name (*optional*)
- Referring Dr Provider Number
- Referral Date
- Referral Period
- Veterans Service Type (*conditional*)
- Treatment Location (*conditional*)
- Benefit Assignment Authorised
- Number of Items
- Item/s
  - Hospital Indicator (*conditional*)
  - Number of Patients Seen (*conditional*)
  - Self Deemed
  - Multiple Procedure Override
  - Duplicate Service Override
  - Charge for Item (*optional*)
  - Service Text (*conditional*)

---

## Notes

**External Patient ID** - this is required so we can uniquely identify the patient. This must be unique to the patient. Everytime a claim is imported, we override the patient details (e.g. first name, last name) for a patient with that same external patient id.

*Token name is: ExternalPatientId*

**Gender** - patient gender.

- F = Female
- M = Male
- I = Indeterminate/Intersex
- N = Not Stated/Inadequately

*Token name is: PatientGender*

**Address** - patient address. Since this is *optional* (not required by the ECLIPSE), unless you want to build your patient database in FYDO, leave the address tokens empty.

*Tokens available:*

- *PatientAddressLine*
- *PatientAddressLocality*
- *PatientPostcode*

**Date Of Service** - This is required to specify the date the service was provided.

*Token name is: DateOfService*

**Time Of Service** - This is only required when the service being claimed requires the specific time the service was rendered. Format HHMM, expressed in 24 hours time e.g. 1435 for 2:35 pm.

*Token name is: TimeOfService*

**Type of Service** - this sets the type of claim, i.e. a Medicare (bulk bill) or a Veterans claim.

- M - Medicare
- V - Veterans
- PC - Patient Claims

*Token name is: TypeOfService*

**Service Type Code** - this sets the service type, i.e. General or Specialist. This should be set to

Specialist.

- S - Specialist

*Token name is: ServiceTypeCde*

**Veterans Service Type** - Indicates the type of claim, only required if 'Type of Service' is V for Veterans. If your services do not fit one of these categories, then it is not required.

- F - Community Nursing
- G - Dental
- L - Optical
- I - Speech Pathology
- J - Allied Health
- K - Psych

*Token name is: VaaServiceTypeCde*

**Treatment Location Code** - This is only required when 'Type of Service' = V (Veterans). For non Veterans claim, keep the token in the file, simply without a value.

- V - Home Visit
- H - Hospital
- R - Rooms
- N - Residential Care facility
- C - Community health centres

*Token name is: TreatmentLocationCde*

**External Servicing ID** - If you are billing under the one provider number, you can skip this field. If however you are billing under multiple provider numbers then we will need something to identify which provider number to use. You do not have to provider the actual provider number, you can place your own unique code, and we will map that code to your actual provider number.

*Token name is: ExtServicingDoctor*

**External Invoice ID** - This is only required if you want to import the data back into your main system. Once claims are paid, we can send you a file back, with your external Invoice ID and Patient ID, so you can match it to the correct invoice/patient. But if you do not intend to import the data back, then you can skip this field.

*Token name is: ExternalInvoice*

**Referring Dr Title / First name / Last name** - these are optional, but we would recommend including it in the file. But not a deal breaker.

*Tokens available:*

- *RefDrFirstName*
- *RefDrLastName*
- *RefDrTitle*
- *RefDrAddress*
- *RefDrSuburb*
- *RefDrState*
- *RefDrPostcode*
- *RefDrPhone*
- *RefDrFax*
- *RefDrEmail*

**Referring Provider Number** - this is mandatory, whilst the referring doctors demographics are optional.

*Token name is: ReferringProviderNum*

**Referral Date** - format is dd/mm/yyyy

*Token name is: ReferralIssueDate*

**Referral Period** - This is the Referral Period in months. This should be set to either 3 (Specialist), 12 (GP) or 99 (Indefinite)

*Token name is: ReferralPeriod*

**Benefit Assignment Authorised** - Indicates that the patient has authorised the assignment of their rights of benefit to a provider. Always indicate authorised.

*Required when 'Type of Service' is M or V, not required when Service Type = P. If set to N, the claim will not import.*

- Y - Authorised

*Token name = BenefitAssignmentAuthorised*

**Number of Items** - this is like a checker that confirms how many items we should be expecting within the claim/invoice.

*Token name = NumberItems*

**Charge [for each Item]** - you do not need to provide any amounts as FYDO can work out the amount when we import the data. If however, you are not charging the Medicare/DVA rate, then you will need to provide the charge amount for each item.

*Token name = ChargeAmount*

**Fee List (Optional)** - If you are manually setting up item fees within FYDO for patient claims, you can specify which fee level number should be applied by including it in the import file. Please note

that if you choose this option, instead of including the charge for each item in the file, you will need to manually update the fees within FYDO whenever there is an increase to your private fees.

*Token name is: feelist*

**Self Deemed** - A Self Deemed service is a service provided by a consultant physician or specialist as an additional service to a valid request. A substituted service is a service provided that has replaced the original service requested.

- SD - Self Deemed (no longer supported by Medicare)
- SS - Substituted Service
- N - Not Self Deemed

*Token name: SelfDeemedCde*

**Multiple Procedure Override Indicator** - Indicates whether the service is part of a multiple procedure or not. For example, if you have to bill an item twice, because it was performed on the left and right leg.

*If set to Y, then the reason for the override must be included in the **Service Text**.*

- Y - Not Multiple
- N - Multiple

*Token name: MultipleProcedureOverrideInd*

**Duplicate Service Override Indicator** - Indicates if the servicing dr attended the patient on more than one occasion on the same day.

- Y - Not Duplicate
- N - Duplicate

If Y, then you will need to add some service text (at the item level) or set the Time of Service field.

*Token name: DuplicateServiceOverrideInd*

**Number of Patients Seen** - this is only required when the item number being billed requires it. For example, home visits, you will need to specify the number of patients seen in that session.

If 5 patients were seen in one session by one provider, then all 5 patients would have a 5 as the 'Number of Patients Seen'.

*Token name is: NoOfPatientsSeen*

**Hospital Indicator** - Indicates if the service was rendered in hospital or not. This field is conditional.

- Y - In hospital
- N - Not in hospital

*Token name: HospitalInd*

**Facility Provider Number** - the provider number of the hospital where the service was rendered.

*Token name is: FacilityId*

**Service Text** - Free text used to provide additional information to assist with the benefit assessment of the service. Only used when absolutely required, as text will mean the claim will need to be manually assessed, which delays the processing.

Limited to 100 characters for Veterans claims, otherwise limited to 50 characters.

*Token name = ServiceText*

### **Only applicable to Patient Claims i.e. Type of Service = PC**

**Claimant Details** - provide this if the claimant is other than the patient. If required, then the following is mandatory: First name, Surname, Medicare Number, Medicare Reference Number, Date of Birth. An example of when this is required, is when the patient is a child under 18 years of age.

The address is not required. It is only required if you need to indicate a temporary address. The address cannot be a PO BOX.

*Tokens available:*

- *ClaimantFamilyName*
- *ClaimantFirstName*
- *ClaimantDateOfBirth*
- *ClaimantMedicareCardNum*
- *ClaimantReferenceNum*
- *ClaimantAddressLine1*
- *ClaimantAddressLine2*
- *ClaimantAddressLocality*
- *ClaimantAddressState*
- *ClaimantAddressPostcode*
- *ClaimantPhone*

**Bank Details** - Only required if the claimant wishes the payment to go to a different account to what they have registered with Medicare.

**Account Paid Indicator** - Indicates whether or not an account has been paid in full.

*Token name = AccountPaidInd*

**Claim Submission Authorised** - Indicates that the claimant has authorised the location to submit the claim on their behalf. Must be set to Y to submit the claim.

- Y - Authorised
- N - Unauthorised

*Token name = ClaimSubmissionAuthorised*

**Patient Contribution [Total]** - Indicates the total the patient has paid for the claim.

**Patient Contribution [for each item]** - Indicates the amount the patient has paid allocated to the item.

---

## Returned Files that can be imported back into your system

This is an optional step and is useful provided your main system can import files.

Read more at [Claims Import - Returned Files - FYDO Wiki](#)

---

## Sample Files

---

## Importing Radiology Claims

To save time double handling your radiology claim data, import your data into FYDO and have the claims paid in approx 1-2 working days from Medicare and DVA.

## Minimum Data Set

Everything is mandatory unless stated otherwise.

### • Patient Info

- External Patient ID
- First Name
- Middle Initial (*optional*)
- Last Name
- Date of Birth
- Gender
- Veterans Affairs Number (*conditional*)
- Medicare Number (*conditional*)
- Medicare Reference Number (*conditional*)
- Claimant Details (*conditional - required for Patient Claims only*)
- Bank Account Details (*conditional - required for Patient Claims only*)

- **Claim Data**

- Type of Service
- Service Type Code
- External Invoice ID (*optional*)
- External Servicing Provider ID
- Referring Dr Title (*optional*)
- Referring Dr details (*optional*)
- Referring Dr Provider Number
- Referral Date
- Referral Period
- Referral Override Type Code (*optional*)
- Location Specific Practice Number (LSPN)
- Benefit Assignment Authorised
- Number of Items
- Date of Service
- Time of Service (*conditional*)
- Item/s
  - Charge for Item (*optional*)
  - Hospital Indicator (*conditional*)
  - Restrictive Override Code (*conditional*)
  - Duplicate Service Override Indicator (*conditional*)
  - Duplicate Service Override Text (*conditional*)
  - Service Text (*conditional*)

---

## Notes

### Patient Fields

**External Patient ID** - this is required so we can uniquely identify the patient. This must be unique to the patient. Everytime a claim is imported, we override the patient details (e.g. first name, last name) for a patient with that same external patient id.

*Token name is: ExternalPatientId*

**Patient Name** - The first and last name are mandatory, the middle initial is not.

Tokens available:

- PatientFirstName
- PatientSecondInitial

- *PatientFamilyName*

**Patient Gender** - patient gender.

- F = Female
- M = Male
- I = Indeterminate/Intersex
- N = Not Stated/Inadequately

*Token name is: PatientGender*

**Patient Medicare / Veterans card** - this is conditional.

If the Type of Service is set to M or P, then the Medicare Number and the Medicare Reference are mandatory.

If the Type of Service is set to V, then the Medicare and Reference Number are not required but the Veterans number is.

*Tokens available:*

- *PatientMedicareCardNum*
- *PatientReferenceNum*
- *VeteranFileNum*

**Address** - patient address. Since this is *optional* (not required by the Medicare), unless you want to build your patient database in FYDO, leave the address tokens empty.

*Tokens available:*

- *PatientAddressLine*
- *PatientAddressLocality*
- *PatientPostcode*

**Date Of Service** - This is required to specify the date the service was provided.

*Token name is: DateOfService*

**Time Of Service** - This is only required when the service being claimed requires the specific time the service was rendered. Format HHMM, expressed in 24 hours time e.g. 1435 for 2:35 pm.

*Token name is: TimeOfService*

**Type of Service** - this sets the type of claim, i.e. a Medicare (bulk bill) or a Veterans claim.

- M - Medicare
- V - Veterans
- PC - Patient Claims

*Token name is: TypeOfService*

**Service Type Code** - this sets the service type, i.e. General or Specialist or Pathology, for example. Medicare classifies radiology as specialist.

- S - Specialist

*Token name is: ServiceTypeCde*

**External Servicing ID** - If you are billing under the one provider number, you can skip this field. If however you are billing under multiple provider numbers then we will need something to identify which provider number to use. You do not have to provider the actual provider number. You can place your own unique code, and we will map that code to your actual provider number.

*Token name is: ExtServicingDoctor*

**External Invoice ID** - This is only required if you want to import the data back into your main system. Once claims are paid, we can send you a file back, with your external Invoice ID and Patient ID, so you can match it to the correct invoice/patient. But if you do not intend to import the data back, then you can skip this field.

*Token name is: ExternalInvoice*

**LSPN** - Location Specific Practice Number.

Must be set if Equipment Id is set.

*Token name: LSPNum*

**Benefit Assignment Authorised** - Indicates that the patient has authorised the assignment of their rights of benefit to a provider. Always indicate authorised.

*Required when 'Type of Service' is M or V, not required when Service Type = P. If set to N, the claim will not import.*

- Y - Authorised

*Token name = BenefitAssignmentAuthorised*

**Treatment Location Code** - This is only required when 'Type of Service' = V (Veterans). For non Veterans claim, keep the token in the file, simply without a value.

- V - Home Visit
- H - Hospital

- R - Rooms
- N - Residential Care facility
- C - Community health centres

*Token name is: TreatmentLocationCde*

**Invoice / Claim Amount [Total]** - this is not required, as FYDO can work out the amount per item and thus the total charge for Bulk Billed claims. If however, you are not charging the Medicare/DVA rate, then you will need to provide the total charge amount.

*Token name = BCImAmt*

**Charge [for each Item]** - you do not need to provide any amounts as FYDO can work out the amount when we import the data. If however, you are not charging the Medicare/DVA rate, then you will need to provide the charge amount for each item.

*Token name = ChargeAmount*

**Fee List (Optional)** - If you are manually setting up item fees within FYDO for Patient Claims, you can specify which fee level number should be applied by including it in the import file. Please note that if you choose this option, instead of including the charge for each item in the file, you will need to manually update the fees within FYDO whenever there is an increase to your private fees.

*Token name is: feelist*

**Number of Items** - this is like a checker that confirms how many items we should be expecting within the claim/invoice.

*Token name = NumberItems*

**Hospital Indicator** - Indicates if the service was rendered in hospital or not. This field is conditional.

- Y - In hospital
- N - Not in hospital

*Token name: HospitalInd*

**Facility Provider Number** - the provider number of the facility where the service was rendered.

*Token name is: FacilityId*

## Referral Fields

**Referring Dr Title / First name / Last name** - these are optional, but we would recommend including it in the file. But not a deal breaker.

*Tokens available:*

- *RefDrFirstName*
- *RefDrLastName*
- *RefDrTitle*
- *RefDrAddress*
- *RefDrSuburb*
- *RefDrState*
- *RefDrPostcode*
- *RefDrPhone*
- *RefDrFax*
- *RefDrEmail*

**Referring Provider Number** - whilst the demographic info about the referrer is optional, the provider number is mandatory.

*Token name is: ReferringProviderNum*

**Referral Date** - Date of the referral.

Format dd/mm/yyyy

*Token name is: ReferralIssueDate*

**Referral Period** - This is the Referral Period in months. This should be set to either 3 (Specialist), 12 (GP) or 99 (Indefinite)

*Token name is: ReferralPeriod*

**Referral Request Type** - Indicates the type of request.

- D - Diagnostic Imaging

*Token name: RequestTypeCde*

**Referral Override Type Code** - Indicates why referral services were provided without referral from another practitioner. This is only required if you do not add referral information.

- L - Lost
- E - Emergency
- H - Hospital
- N - Not required (non referred)
- R - remote Exemption (DVA Only)

*Token name: RequestOverrideTypeCde*

## Fields related to the Item

**Restrictive Override Code** - Indicator used to allow payment for service where the account

provides indication that the service is not restrictive with another service either within the same claim or on the patient history.

- SP - Separate Sites
- NR - Not Related (Care Plans)
- NC - Not for comparison

*Note, this can not be set if the Service Type Code = P*

*Token name: RestrictiveOverrideInd*

**Duplicate Service Override Indicator** - indicates if the practitioner attended the patient on more than one occasion on the same day.

- Y - Not Duplicate
- N - Duplicate

*Note, this can not be set if Service Type Code = P*

*Token name: DuplicateServiceOverrideInd*

**Time of Service** - The time the service was rendered. This field is conditional.

Format HH:MM, expressed in 24 hours time e.g. 14:35 for 2:35 pm.

This field must be set if any of 'Duplicate Service Override' Indicator, 'Multiple Procedure Override Indicator' or 'Rule 3 Exemption' are set to to Y.

*Token name is: TimeOfService*

**Service Text** - Free text used to provide additional information to assist with the benefit assessment of the service. Only used when absolutely required, as text will mean the claim will need to be manually assessed, which delays the processing.

*Token name = ServiceText*

Limited to 100 characters for Veterans claims, otherwise limited to 50 characters.

### **Only applicable to Patient Claims i.e. Type of Service = PC**

**Claimant Details** - provide this if the claimant is other than the patient. If required, then the following is mandatory: First name, Surname, Medicare Number, Medicare Reference Number, Date of Birth. An example of when this is required is when the patient is a child under 18 years of age.

The address is not required. It is only required if you need to indicate a temporary address. The address cannot be a PO BOX.

*Tokens available:*

- *ClaimantFamilyName*
- *ClaimantFirstName*
- *ClaimantDateOfBirth*
- *ClaimantMedicareCardNum*
- *ClaimantReferenceNum*
- *ClaimantAddressLine1*
- *ClaimantAddressLine2*
- *ClaimantAddressLocality*
- *ClaimantAddressState*
- *ClaimantAddressPostcode*
- *ClaimantPhone*

**Bank Details** - Only required if the claimant wishes the payment to go to a different account to what they have registered with Medicare.

**Account Paid Indicator** - Indicates whether or not an account has been paid in full.

*Token name* = *AccountPaidInd*

**Claim Submission Authorised** - Indicates that the claimant has authorised the location to submit the claim on their behalf. Must be set to Y to submit the claim.

- Y - Authorised
- N - Unauthorised

*Token name* = *ClaimSubmissionAuthorised*

**Patient Contribution [Total]** - Indicates the total the patient has paid for the claim.

**Patient Contribution [for each item]** - Indicates the amount the patient has paid allocated to the item.

---

## Returned Files that can be imported back into your system

This is an optional step and is useful provided your main system can import files.

Read more at [Claims Import - Returned Files - FYDO Wiki](#)

---

## Sample Files

---

# Importing Pathology Claims - Medicare / DVA / Patient Claims

To save time double handling your pathology claim data, import your data into FYDO and have the claims paid in approx 14 days from Medicare and DVA.

## Minimum Data Set

Everything is mandatory unless stated otherwise.

- **Patient Info**

- External Patient ID
- First Name
- Middle Initial (*optional*)
- Last Name
- Date of Birth
- Gender
- Veterans Affairs Number (*conditional*)
- Medicare Number (*conditional*)
- Medicare Reference Number (*conditional*)
- Claimant Details (*conditional - required for Patient Claims only*)
- Bank Account Details (*conditional - required for Patient Claims only*)

- **Claim Data**

- Type of Service
- Service Type Code
- External Invoice ID (*optional*)
- External Servicing Provider ID
- Referring Dr Title (*optional*)
- Referring Dr First name (*optional*)
- Referring Dr Last name (*optional*)
- Referring Dr Provider Number
- Referral Date
- Referral Period
- Specimen Collection Point (SCP)
- Benefit Assignment Authorised
- Number of Items
- Date of Service
- Time of Service (*conditional*)
- Item/s
  - Hospital Indicator (*conditional*)
  - Rule 3 Exempt Indicator
  - S4B3 Exempt Indicator
  - Collection Date and Time
  - Accession Date and Time

- Charge for Item (*optional*)
- Service Text (*conditional*)

---

## Notes

**External Patient ID** - this is required so we can uniquely identify the patient. This must be unique to the patient. Everytime a claim is imported, we override the patient details (e.g. first name, last name) for a patient with that same external patient id.

*Token name is: ExternalPatientId*

**Patient Name** - The first and last name are mandatory, the middle initial is not.

Tokens available:

- PatientFirstName
- PatientSecondInitial
- PatientFamilyName

**Patient Gender** - patient gender.

- F = Female
- M = Male
- I = Indeterminate/Intersex
- N = Not Stated/Inadequately

*Token name is: PatientGender*

**Patient Medicare / Veterans card** - this is conditional.

If the Type of Service is set to M or P, then the Medicare Number and the Medicare Reference are mandatory.

If the Type of Service is set to V, then the Medicare and Reference Number are not required but the Veterans number is.

Tokens available:

- PatientMedicareCardNum
- PatientReferenceNum
- VeteranFileNum

**Address** - patient address, since this is *optional* (not required by the ECLIPSE), unless you want to build your patient database in FYDO, leave the address tokens empty.

*Tokens available:*

- PatientAddressLine
- PatientAddressLocality
- PatientPostcode

**Date Of Service** - This is required to specify the date the service was provided.

*Token name is: DateOfService*

**Time Of Service** - This is only required when the service being claimed requires the specific time the service was rendered. Format HHMM, expressed in 24 hours time e.g. 1435 for 2:35 pm.

*Token name is: TimeOfService*

**Type of Service** - this sets the type of claim i.e. a Medicare (bulk bill) or a Veterans claim.

- M - Medicare
- V - Veterans
- PC - Patient Claims

*Token name is: TypeOfService*

**Service Type Code** - this sets the service type i.e. General or Specialist or Pathology for example

- P - Pathology

*Token name is: ServiceTypeCde*

**External Servicing ID** - If you are billing under the one provider number, you can skip this field. If however you are billing under multiple provider numbers then we will need something to identify which provider number to use. You do not have to provider the actual provider number, you can place your own unique code, and we will map that code to your actual provider number.

*Token name is: ExtServicingDoctor*

**External Invoice ID** - This is only required, if you want to import the data back into your main system. Once claims are paid, we can send you a file back, with your external Invoice ID and Patient

ID, so you can match it to the correct invoice/patient. But if you do not intend to import the data back, then you can skip this field.

*Token name is: ExternalInvoice*

**Referring Dr Title / First name / Last name** - these are optional, but we would recommend including it in the file. But not a deal breaker.

*Tokens available:*

- *RefDrFirstName*
- *RefDrLastName*
- *RefDrTitle*
- *RefDrAddress*
- *RefDrSuburb*
- *RefDrState*
- *RefDrPostcode*
- *RefDrPhone*
- *RefDrfax*
- *RefDrEmail*

**Referring Provider Number** - whilst the demographic info about the referrer is optional, the provider number is mandatory.

*Token name is: ReferringProviderNum*

**Referral Date** - Date of the referral.

Format dd/mm/yyyy

*Token name is: ReferralIssueDate*

**Referral Period** - This is the Referral Period in months. This should be set to either 3 (Specialist), 12 (GP) or 99 (Indefinite)

*Token name: ReferralPeriod*

**Referral Request Type** - Indicates the type of request.

- P - Pathology
- D - Diagnostic Imaging

*Token name: RequestTypeCde*

**Specimen Collection Point** - code provided to each pathology lab.

*Token name = SCPId*

**Benefit Assignment Authorised** - Indicates that the patient has authorised the assignment of

their rights of benefit to a provider. Always indicate authorised.

*Required when 'Type of Service' is M or V, not required when Service Type = P. If set to N, the claim will import but the claim will be printed, basically it reverts back to manual not electronic submission.*

- Y - Authorised
- N - Not Authorised

*Token name = BenefitAssignmentAuthorised*

**Treatment Location Code** - This is only required when 'Type of Service' = V (Veterans). For non Veterans claim, keep the token in the file, simply without a value.

- V - Home Visit
- H - Hospital
- R - Rooms
- N - Residential Care facility
- C - Community health centres

*Token name is: TreatmentLocationCde*

**Invoice / Claim Amount [Total]** - this is not required, as FYDO can work out the amount per item and thus the total charge for Bulk Billed claims. If however, you are not charging the Medicare/DVA rate, then you will need to provide the total charge amount.

*Token name = BCImAmt*

**Charge [for each Item]** - you do not need to provide any amounts as FYDO can work out the amount when we import the data. If however, you are not charging the Medicare/DVA rate, then you will need to provide the charge amount for each item.

*Token name = ChargeAmount*

**Fee List (Optional)** - If you are manually setting up item fees within FYDO for patient claims, you can specify which fee level number should be applied by including it in the import file. Please note that if you choose this option, instead of including the charge for each item in the file, you will need to manually update the fees within FYDO whenever there is an increase to your private fees.

*Token name is: feelist*

**Number of Items** - this is like checker, that confirms how many items we should be expecting within the claim/invoice.

*Token name = NumberItems*

**Hospital Indicator** - Indicates if the service was rendered in hospital or not. This field is conditional.

- Y - In hospital
- N - Not in hospital

If the 'Type of Service' is M or PC, this field is required.

If the 'Type of Service' is V, then this field is not required, and not required in the file at all.

If Y, then the hospital provider number needs to be provided in the service text field.

Since this is at the item level, if 2 items are invoiced and the service was provided in hospital, the provider number (of the hospital) would be in the service text for both items.

When In Hospital and 'Type of Service ' is set to V, then the only thing to do place the hospital provider number in the service text.

*Token name: HospitalInd*

**Rule 3 Exempt Indicator** - used to indicate Rule 3 in the Medicare Benefits Schedule applies to the pathology service and indicates the patient had multiple pathology tests with a 24 hr period due to a chronic illness, resulting in a a higher rate.

*Token name = Rule3ExemptInd*

*If set to Yes, the 'Time Of Service' must be set and 'S4B3 Exempt Indicator' cant be set to Y.*

**S4B3 Exempt Indicator** - Flags the associated service as requiring assessing in accordance with S4B3 requirements of the MBS.

- Y - Exempt
- N - Not Exempt

*Token name = S4B3ExemptInd*

*If set to Yes, then must set 'Accession Date and Time' as well as the 'Collection Date and Time'.*

*All services for the same patient for a 24 hr period should contain both 'Accession Date and Time' as well as the 'Collection Date and Time'.*

**Collection Date and Time** - This is the date and time the actual pathology sample was taken/extracted from the patient whether this be blood, tissue or a spontaneous ejection.

Format DDMMYYYYHHMM e.g. 300620161330

Must be set if S4B3 Exemption Indicator is set to Y.

Must be present if Accession Date & Time is present.

*Token name = CollectionDateTime*

**Accession Date and Time** - This is the date and time when the pathology test was actually performed.

Format DDMMYYYYHHMM e.g. 300620161330

Must be

*Token name = AccessionDateTime*

**Time of Service** - The time the service was rendered. This field is conditional.

Format HHMM, expressed in 24 hours time e.g. 1435 for 2:35 pm.

This field must be set if any of 'Duplicate Service Override' Indicator, 'Multiple Procedure Override Indicator' or 'Rule 3 Exemption' are set to to Y.

*Token name is: TimeOfService*

**Service Text** - Free text used to provide additional information to assist with the benefit assessment of the service. Only used when absolutely required, as text will mean the claim will need to be manually assessed, which delays the processing.

*Token name = ServiceText*

Limited to 100 characters for Veterans claims, otherwise limited to 50 characters.

## **Only applicable to Patient Claims i.e. Type of Service = PC**

**Claimant Details** - provide this if the claimant is other than the patient. If required, then the following is mandatory: First name, Surname, Medicare Number, Medicare Reference Number, Date of Birth. An example of when this is required, is when the patient is a child under 18 years of age.

The address is not required, it is only required, if you need to indicate a temporary address. The address can not be a PO BOX.

*Tokens available:*

- *ClaimantFamilyName*
- *ClaimantFirstName*
- *ClaimantDateOfBirth*
- *ClaimantMedicareCardNum*
- *ClaimantReferenceNum*
- *ClaimantAddressLine1*
- *ClaimantAddressLine2*
- *ClaimantAddressLocality*
- *ClaimantAddressState*
- *ClaimantAddressPostcode*
- *ClaimantPhone*

**Bank Details** - Only required if, the claimant wishes the payment to go to a different account to what they have registered with Medicare.

**Account Paid Indicator** - Indicates whether or not an account has been paid in full.

*Token name = AccountPaidInd*

**Claim Submission Authorised** - Indicates that the claimant has authorised the location to submit the claim on their behalf. Must be set to Y to submit the claim.

- Y - Authorised
- N - Unauthorised

*Token name = ClaimSubmissionAuthorised*

**Patient Contribution [Total]** - Indicates the total the patient has paid for the claim.

**Patient Contribution [for each item]** - Indicates the amount the patient has paid allocated to the item.

---

## **Returned Files that can be imported back into your system**

This is an optional step, and is useful provided your main system can import files.

Read more at [Claims Import - Returned Files - FYDO Wiki](#)

---

## **Sample Files**