

# 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*)

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# 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 provide 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.

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## 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](#)

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## Sample Files

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# [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*)

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## 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 provide 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 = SCPIId*

**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 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 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.

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## 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](#)

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## Sample Files

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# Importing General Practice Claims

To save time double handling your claim data for your GP services, import your data into FYDO and have the claims paid within 1-3 business day.

We accept two file formats (excel and XML) to import your claim data.

## **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
  - Veteran Number (conditional)
  - Medicare Number (conditional)
  - Medicare Reference Number (conditional)
  - AcceptedDisabilityInd and Text
  
- Claim Data
  - Type of Service
  - Service Type Code
  - Treatment Location
  - External Invoice ID (optional)
  - External Servicing ID (optional)
  - Benefit Assignment Authorised (mandatory when using XML format, otherwise not required)
  - Date Of Service
  - Time of Service (*conditional*)
  - Item
    - No Of Patients Seen (conditional)
    - Distance in KMs (conditional)
    - Charge (optional)
    - Multiple Procedure Override
    - Duplicate Service Override

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## 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*

**Medicare / Veterans Number** - this is conditional, as it depends on the Type of Service. So if the service is to be bulked billed then the medicare number is mandatory and if the service is to sent to Veterans Affairs, then the Veterans number is mandatory.

If you plan to use the excel format, you do not necessarily need a column for each. You could just use the Medicare Number column, and insert the Medicare number or the Veterans number, and then based on 'Type of Service' we will know what to expect.

You could format the medicare number anyway you like

e.g. 211111111 or 2111-11111-1 or 2111 11111 1

*Token name is: PatientMedicareCardNum or VeteranFileNum*

**Medicare Reference Number** - this is mandatory, however if you can not provide it in the file, we will assume it as 1 and then Medicare will still assess and pay the claim if everything else is correct. Medicare just wants a value in there, can not be 0 or empty.

*Token name is: PatientReferenceNum*

**Accepted Disability Indicator** - indicates whether the service rendered are for a White Card holder and the service is in accordance with the White Card condition. The back of the DVA card for White Card holders will list any exclusions e.g. hearing, imaging etc. If the card is not white, then default this to N - No.

Y - Condition treated relates to a condition for a White Card holder

N - Condition does not relate to a condition for a White Card holder

If you answer Y - Yes, then you must add text to the Accepted Disability text field.

*Token name is: AcceptedDisabilityInd*

**Accepted Disability Text** - free text used to provide details regarding the condition being treated

in conjunction with Accepted Disability Indicator.

Examples of the text could be the reason for the service. In the case of community nursing, simply add 'community nursing'.

*Token name is: AcceptedDisabilityText*

**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

- G - General

*Token name is: ServiceTypeCde*

**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*

**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*

**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 provide 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*

**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'. This does not reset or is grouped by item number, but rather the entire visit.

*Token name is: NoOfPatientsSeen*

**Distance in KMs** - this is only required when you travel to see the patient where the distance travelled is over 10 kms and when the service type is Veterans. Only applicable when the 'Type Of Service' is Veterans.

The value should be an integer, no decimals.

*Token name is: DistanceKms*

**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*

**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*

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## 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](#)

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## Sample File

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## Tips

- The column order in the Excel file is not important.
- Each row represents one claim/invoice.

---

## Importing Allied Health Claims

To save time double handling your claim data for your allied health services, import your data into FYDO and have the claims paid within 1-3 business day by Medicare / Department of Veterans Affairs.

We accept two file formats (excel and XML) to import your claim data.

### 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 (*conditional - if a Medicare claim*)
  - Medicare Reference Number (*conditional - if a Medicare claim*)
  - Veterans Number (*conditional - if a Veterans claim*)
  - Accepted Disability Indicator (*conditional- if a Veterans claim*)
  - Accepted Disability Text (*conditional- if a Veterans claim*)
  - 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
  - Veterans Service Type
  - Treatment Location (*conditional - if a Veterans claim*)
  - Benefit Assignment Authorised (*for xml only*)
  - Referring Dr Title (*optional*)

- Referring Dr First name (*optional*)
- Referring Dr Last name (*optional*)
- Referring Dr Provider Number (*conditional*)
- Referral Date (*conditional*)
- Referral Type (*conditional*)
- Date of Service
- Time of Service (*conditional*)
- Item
  - No Of Patients Seen (*conditional*)
  - Distance in KMs (*conditional*)
  - Charge (*optional*)
  - Service Text (*optional*)

---

## 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*

**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*

**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 you plan to use the Excel format, you do not necessarily need a column for each. You could just use the Medicare Number column, and insert the Medicare number or the Veterans number, and then based on 'Type of Service' we will know what to expect.

You could format the Medicare number anyway you like  
e.g. 211111111 or 2111-11111-1 or 2111 11111 1

The Medicare reference is mandatory. However, if you cannot provide it in the file, we will assume it as 1 and then Medicare will still assess and pay the claim if everything else is correct. Medicare just wants a value in there. It cannot be 0 or empty.

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*

**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 does 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 provide 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*

**Accepted Disability Indicator** - indicates whether the service rendered are for a White Card holder and the service is in accordance with the White Card condition. The back of the DVA card for White Card holders will list any exclusions, e.g. hearing, imaging etc. If the card is not white, then default this to N - No.

Y - Condition treated relates to a condition for a White Card holder  
N - Condition does not relate to a condition for a White Card holder

If you answer Y - Yes, then you must add text to the Accepted Disability text field.

*Token name is: AcceptedDisabilityInd*

**Accepted Disability Text** - free text used to provide details regarding the condition being treated in conjunction with Accepted Disability Indicator.

Examples of the text could be the reason for the service. In the case of community nursing, simply add 'community nursing'.

*Token name is: AcceptedDisabilityText*

**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 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'. This does not reset or is grouped by item number, but rather the entire visit.

*Token name is: NoOfPatientsSeen*

**Distance in KMs** - this is only required when you travel to see the patient where the distance travelled is over 10 kms and when the service type is Veterans. Only applicable when the 'Type Of Service' is Veterans.

The value should be an integer, no decimals.

*Token name is: DistanceKms*

**Referring Provider Number** - provider number of the referring doctor. This is a conditional field. If the type of claim requires referral details, then include it, otherwise leave blank.

*Token name is: ReferringProviderNum*

**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*

**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*

**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 = BClmAmt*

**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*

## **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](#)

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## Sample File

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# Importing Community Nursing Claims

To save time double handling your claim data for your community nursing services, import your data into FYDO and have the claims paid within 1-3 business day.

We have two file formats (excel and XML) to import your claim data.

## **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
- Accepted Disability Indicator (conditional)
- Accepted Disability Text (conditional)

- **Claim Data**

- Type Of Service
- Veterans Service Type
- Benefit Assignment Authorised (mandatory when using **XML** format, otherwise not required)
- External Invoice ID (optional)
- External Servicing provider ID
- Date of Service
- Admission date
- Discharge date (conditional)
- Break in episode of care (conditional)
- Start date of break (conditional)
- End date of break (conditional)
- Referring Dr Title (optional)
- Referring Dr First name (optional)
- Referring Dr Last name (optional)
- Referring Dr provider Number
- Referral date
- Referral type (optional)
- Number of Items (mandatory when using **XML** format, otherwise not required)
- Treatment Location (mandatory when using **XML** format, otherwise not required if you will only ever have 1 location type).
- CNC Hours
- CNC Visits

- EN Hours
- EN Visits
- NSS Hours
- NSS Visits
- RN Hours
- RN Visits
- Item
- Charge

## 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*

**Accepted Disability Indicator** - indicates whether the service rendered are for a White Card holder and the service is in accordance with the White Card condition. The back of the DVA card for White Card holders will list any exclusions e.g. hearing, imaging etc. If the card is not white, then default this to N - No.

Y - Condition treated relates to a condition for a White Card holder

N - Condition does not relate to a condition for a White Card holder

If you answer Y - Yes, then you must add text to the Accepted Disability text field.

*Token name is: AcceptedDisabilityInd*

**Accepted Disability Text** - free text used to provide details regarding the condition being treated in conjunction with Accepted Disability Indicator.

Examples of the text could be the reason for the service. In the case of community nursing, simply add 'community nursing'.

*Token name is: AcceptedDisabilityText*

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

- M - Medicare
- V - Veterans
- P - Patient Claims

*Token name is: TypeOfService*

**Veterans Service Type** - only required when using the XML format.

- F - Community Nursing

*Token name is: VaaServiceTypeCde*

**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*

**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 provide 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** - provider number of the referring doctor.

*Token name is: ReferringProviderNum*

**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*

**Date of Service** - this is the first day of the 28 day cycle.

**Discharge Date** - Only required if the patient has been discharged.

**Break in episode of care** - this is only required if the patient had a break in their episode of care. The value for this field is:

- 1 - Admission Acute
- 2 - Admission to respite/rehab
- 3 - holiday
- 4 - Discharge from care
- 5 - Death

If the patient did have a break, then also specify the start and end dates of the break.

**Additional Travel Item NA10** - Only required if travel is being claimed for the patient. FYDO will work out the amount to charge based on the number of KMs enter in file.

*Token name is: DistanceKMs*

**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.

The only time you will need to set a dollar value is when you have negotiated a fee with DVA.

The only items that have a negotiated rate are:

- NO65 OTHER ITEMS - Exceptional Case
- NO66 OTHER ITEMS - Palliative Overnight
- NO67 OTHER ITEMS - Clinical Assessment
- NO68 OTHER ITEMS - Second Worker

The value should be ex GST.

*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*

## **Items per Voucher/Invoice**

**Recommended Structure for Hours & Visits, while DVA should accept all items within the one voucher, we have found that DVA rejects vouchers where items attract nurse hours, so we recommend splitting items as explained below. However, if you do not split the items, DVA 'might' process it, we just can't know if they will or not.**

If you need to report hours for an item number, we recommend you will need to split the items into its own voucher/invoice.

For example, if you need to bill:

- NP03 (core item)
- NS10 (add on item)
- NA02 (assessment item)

These 3 items have hours and visits associated to them, so this would need to be split into 3 invoices. In each voucher/invoice, put the hours just for that item, not the total nurse hours and visits.

If, however, you need to bill:

- NP03 (core item)
- NC10 (consumable item)

Since the consumable item doesn't need any hours or visits recorded, it can be in the one voucher with the core item.

If you decide not to split the items, then the hours and visits should be the total hours and visits for all items. So, the sum of the hours and visits at the voucher level.

Please Note - Nursing hours are calculated as a decimal value:

- 1 hour = 1.0
- 1 hour 15 mins = 1.25
- 1 hour 30 mins = 1.5
- 1 hour 45 mins = 1.75

## 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 File

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### Tips

**If using the Excel format:**

- The column order in the Excel file is not important.
- Each row represents one claim/invoice.

For those items that attract a negotiated rate, if you omit the amount, FYDO will not allow you to submit the claim/invoice, as a \$0 dollar cannot be sent to DVA.

**If using the XML format:**

- Regarding the hrs and visits of the nurses, when creating the claim, if a claim did not require a Registered Nurse (RN), you will still need those tokens in the XML file, with a blank/empty value.
- 

## DVA reference site

DVA have a website full of information specifically for community nursing providers. It is quite informative <http://www.dva.gov.au/providers/community-nursing>

To find out more about the item numbers available to community nursing providers, please refer to DVA Community Nursing Fee Schedule - [DVA Community Nursing Schedule of Fees - March 2025](#)

## [Your New FYDO Dashboard!](#)

We're excited to announce the launch of a **long-awaited update** to your FYDO Dashboard!

The first stage of this update will deliver valuable new content, and allow you to click on links to find helpful information, including:

- **FYDO Updates** - Stay informed with the latest news and insights.
- **FYDO Information** - Have Altura Health contact information at your fingertips.
- **Feature Spotlights** - Learn more about existing FYDO features you may not be using yet!
- **New Feature Announcements** - Be the first to know when new tools and enhancements go live.



We know many of you have been eagerly awaiting this Dashboard refresh, and this is just the beginning! We'll continue expanding and refining it to give you faster, easier access to the information you need.

**Thank you for being part of the FYDO journey — we're thrilled to keep building better solutions for you!**

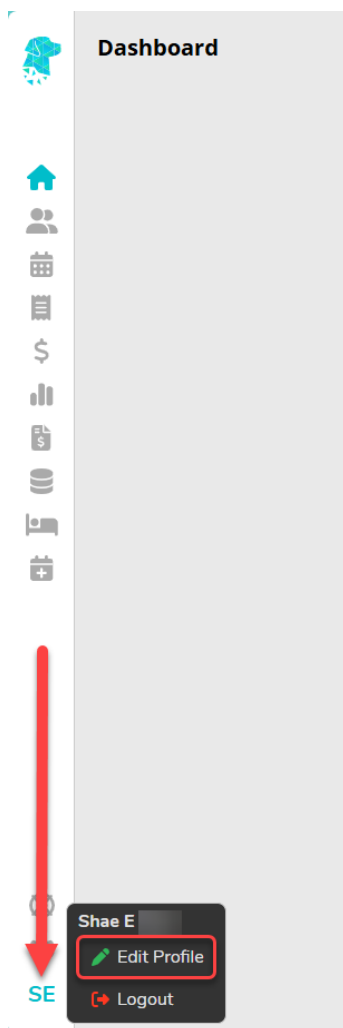
If you have any questions or feedback, feel free to reach out to our Altura Health Team.

---

## Updating a Username

There may be instances when a user needs to change their name in FYDO. This can be done by the user themselves, by following the steps below.

1. Hover over **User Profile** (*Your Initials*)
2. Select **Edit Profile**



3. While on the **User Details** tab, select **Edit**

**Edit Profile - Shae E**

User Details

First Name: Shae

Surname: E

Email: support@alturahealth.com.au

TimeZone: Australia - (UTC+10:00) Brisbane

[Edit](#)

- Amend the required **First Name** or **Surname** fields
- Click **Save**

**Edit Profile - Shae E Darr**

User Details

First Name: Shae

Surname: Testing

Email: support@alturahealth.com.au

TimeZone: Australia - (UTC+10:00) Brisbane

[Cancel](#) [Save](#)

## Re-Order Patient Screen

Users can customise the **Patient Screen** and display the details that are most relevant to them!

**253 - KNIGHT, Kelvin ~ Kel (16/05/1959 - 65)**

Patient Details

Title: Mr, Pronouns: He/Him/His, File Number, External ID

First Name: Kelvin, Middle Name

Last Name: KNIGHT, Previous Name

Preferred Name: Kel, Date of Birth: 16/05/1959, DOB Estimate

Sex: Male, Gender: Man, or boy, or male

Address: 123 The Lakes Drive, Suburb: FOUNTAIN LAKES, State: VIC, Postcode: 3000

Mobile, Home, Work, Email

Medicare / DVA

Medicare Number, Ref, Expiry, Eligibility

Veterans No., Veteran Card Colour, DVA Auth.No, DVA Auth. Date

Entitlement Cards

Card Type, Card Number, Expiry

Health Fund

Fund Name

Membership No., UPI, Insurance Status

Alias Name, Alias Surname

Online Patient Verification (OPV)

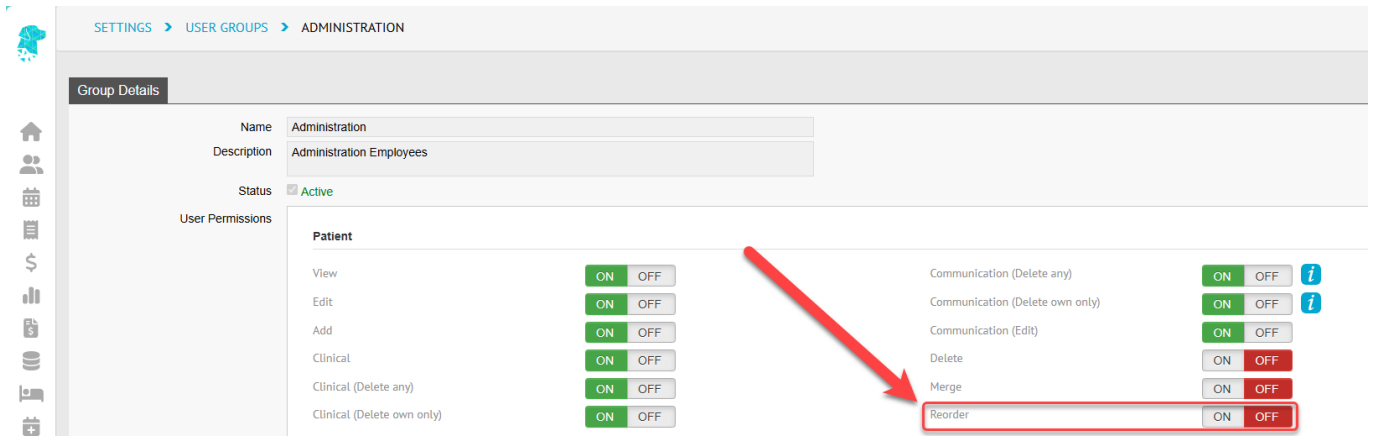
Type: Medicare, As at: 03/03/2025, OPV Check

Last Medicare Check

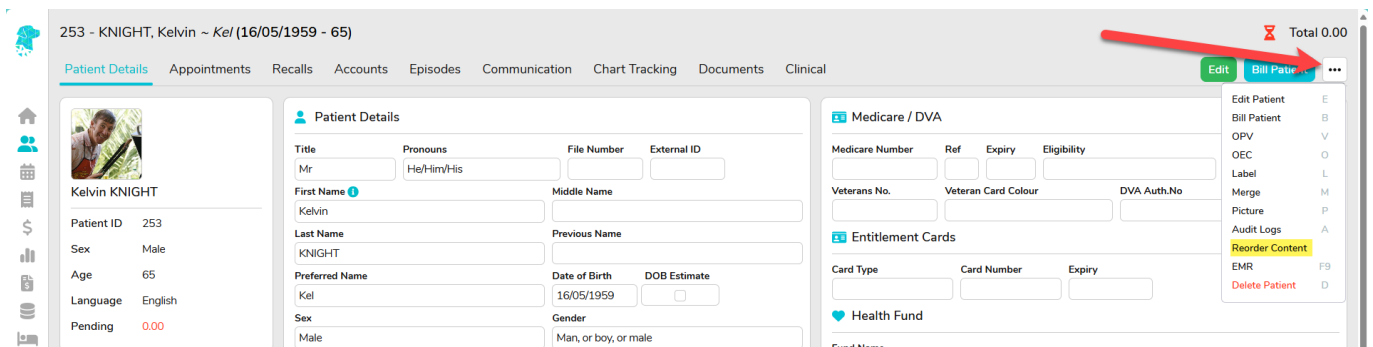
Location: Shaes Private Hospital

Health Identifier

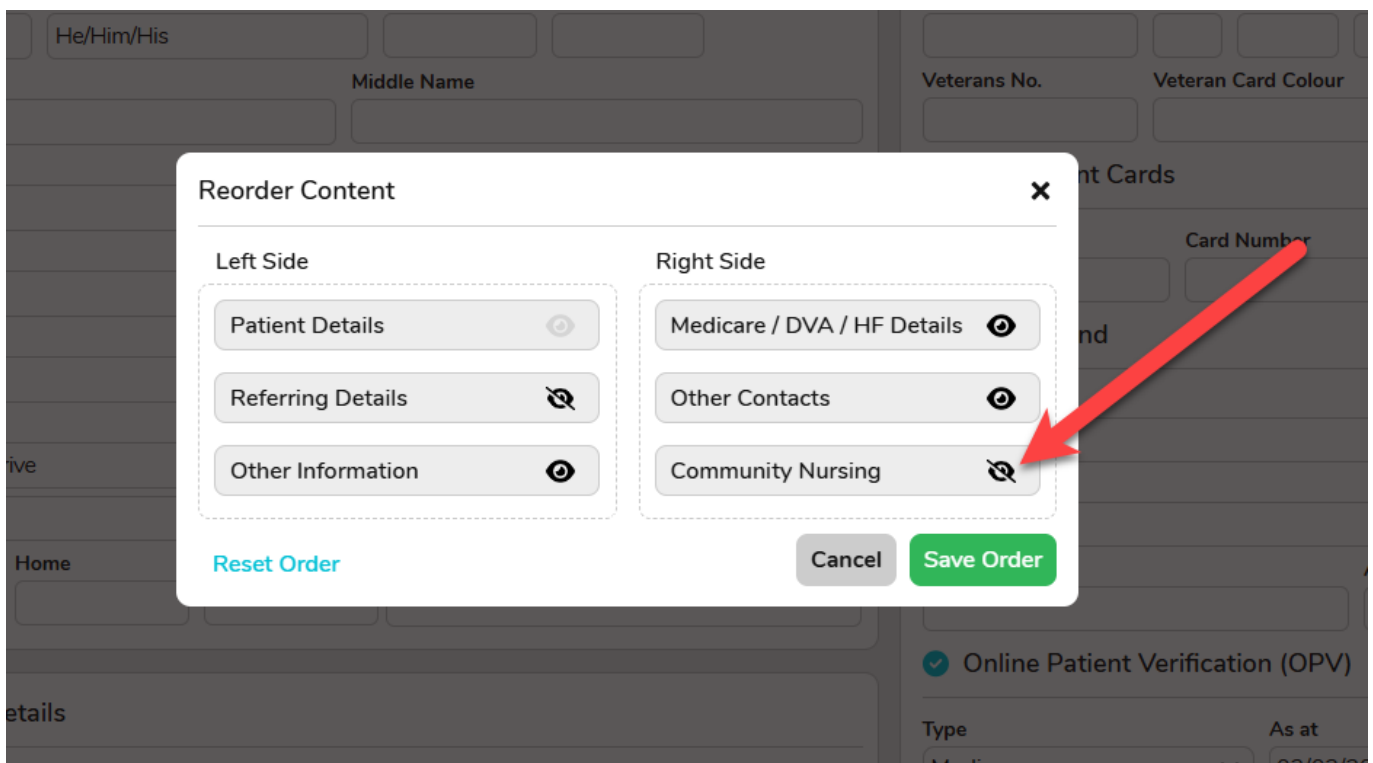
Access to this feature is managed at the User Group level, via **Settings > User Groups**, by amending the option under **Patient** for **Reorder**.



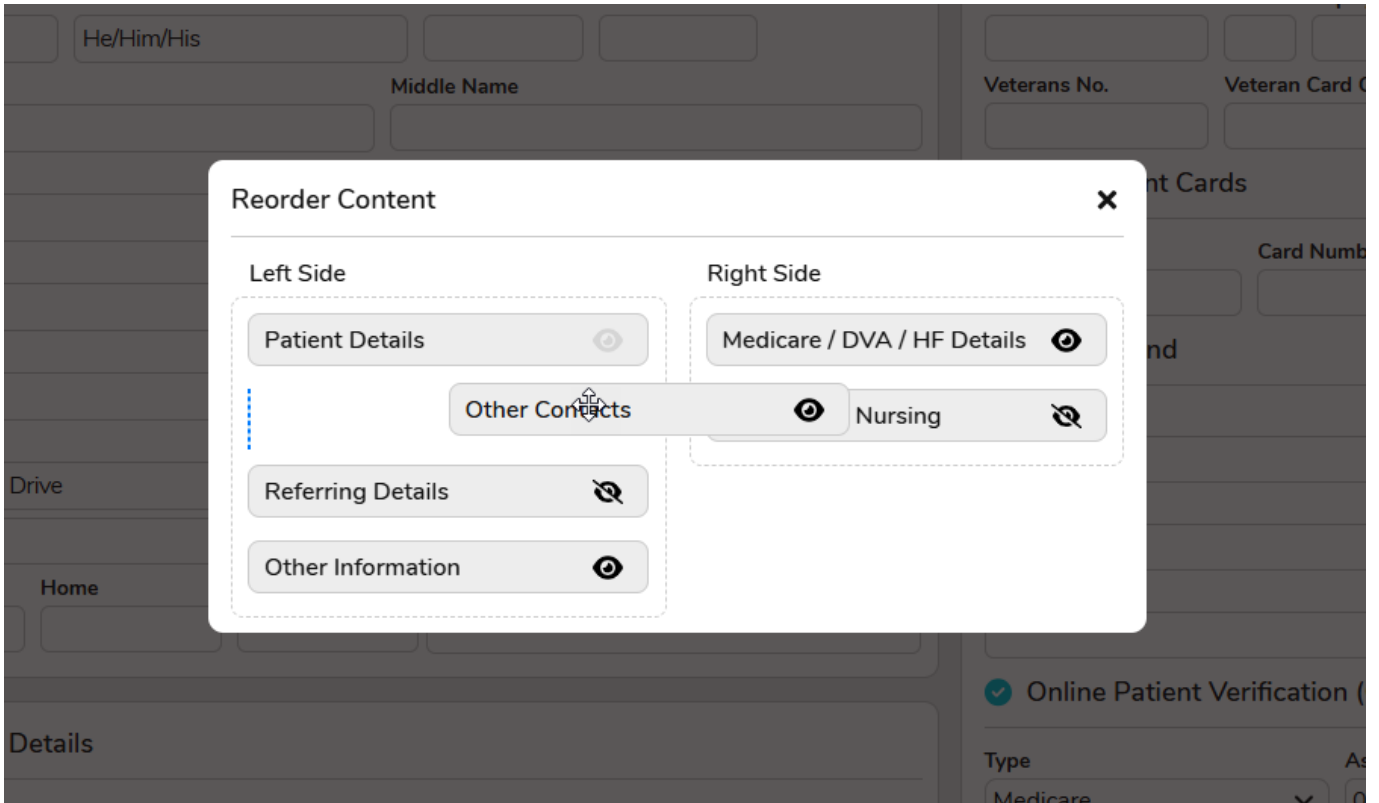
Users with the appropriate access levels can customise the layout of the patient screen by navigating to any patient and selecting **Reorder Content** from the **Menu** in the top-right corner.



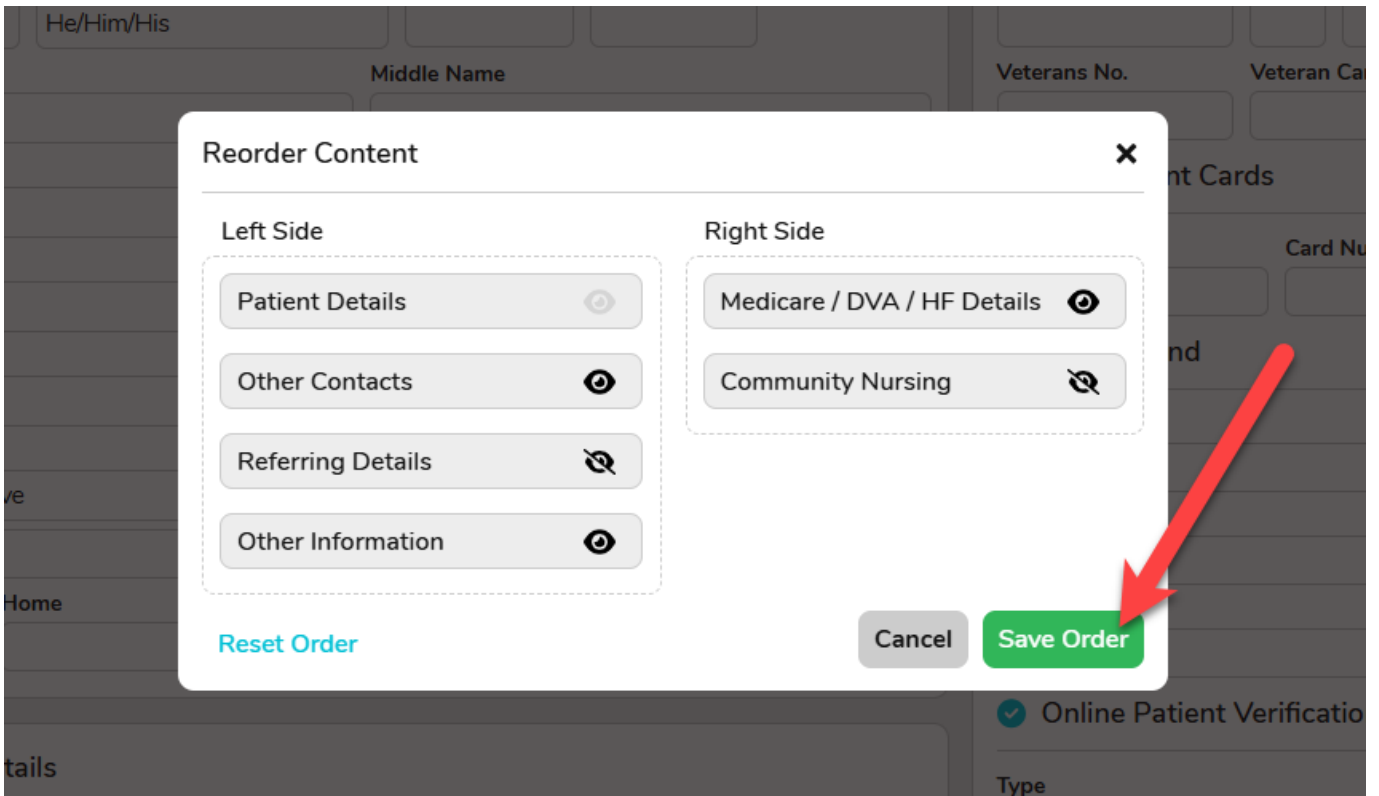
This allows users to choose which groups of information are visible and hide irrelevant details using the eye icon.



Information groups can also be **Reordered** by dragging them to the appropriate spot. The layout can be displayed across two columns or condense it into a single column if needed.



Once the desired order has been selected, click **Save Order** and the view will be displayed whenever the **Patient Screen** is opened.



# SMS Automation in FYDO

Stay connected with your patients effortlessly with the new **Automated SMS** feature in FYDO! This feature allows you to automatically send SMSs to patients before and after their admissions, at timeframes that work for you!

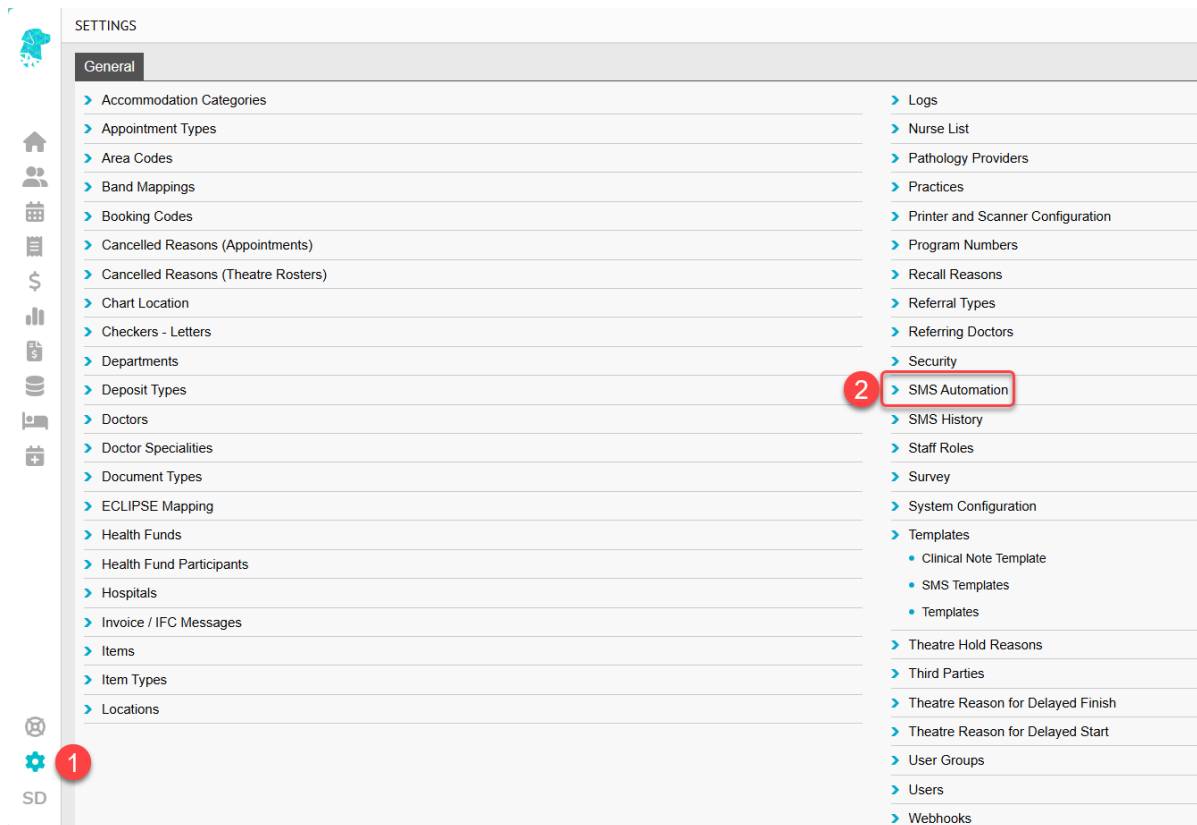
- Need to send patients their admission times? Done.
- Need to remind patients to complete their Admission Form? No problem.
- Want to send a Post-Discharge follow-up or request feedback via a Patient Survey? It's all possible!

[support@alturahealth.com.au](mailto:support@alturahealth.com.au)

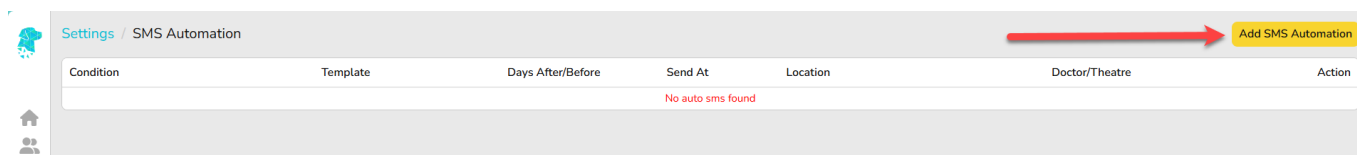
To start using the **Automated SMS** feature, here's what you'll need to have in place:

- **An SMS Account:** You'll need an SMS account set up in FYDO. If you're not sure whether you already have one, contact our team.
- **SMS Templates:** You'll need to set up SMS Templates. Detailed instructions are available on our [Adding SMS templates - FYDO Wiki](#)
- **SMS Automation:** Once your templates are ready, you'll need to set up SMS Automation in the FYDO Settings. Let's walk through that now!

1. Navigate to **Settings**
2. Select **SMS Automation**



### 3. Click **Add SMS Automation**



4. Select the **Condition**. (We will go into detail on each of the **Conditions** later in the instructions and explain what field in FYDO governs their status)
5. Select the required **Template**
6. Select the **Number of Days Before** or **After** the episode that you'd like the SMS to be sent
7. Select the **Time** that you'd like the SMS sent
8. Select the **Location** for Multi-Location databases. (Single location databases will not need to amend this field)
9. Select the specific **Theatre** if this Automated SMS is only going to apply to one. Otherwise leave the selection as **All Theatres**
10. Click **Setup Auto SMS**

### SMS Automation

---

**Condition**  
To Confirm Appointment 4 ▼

**Template**  
Pre-Admission Text 5 ▼

**Days Before** 6 0 **Send At** 7 06:37 PM

**Location** 8 Shaes Private Hospital ▼ **Doctor/Theatre** 9 All Theatres ▼

10

## To Confirm Appointment

This type of SMS automation is triggered by the **Confirmed** field in the **Edit Appointment Screen** of each episode. When the Automated SMS Condition is set to **To Confirm Appointment** this field will be checked before sending, to ensure the message is only sent to appointments that haven't been confirmed yet.

Appointments / Edit Appointment

FLINSTONE, Frederick

MRN 167  
File No -  
DOB 02/02/1954 (71)  
Sex Male  
Mobile 0400 494 029  
Medicare -  
Veterans -

**Allergies**  
Nil

**Alert**  
Diabetic

**Notes**  
-

**Document Alert**  
-

**Booking Details**

Location Shaes Private Hospital  
Theatre/List Theatre 1 Roster Select Roster  
Dr/Surgeon HOUSE, Dr Greg  
Surgical Assistant MURPHY, Dr Shaun  
Other Surgical Assistant PIERCE, Dr Hawkeye  
Anaesthetist STARR, Dr Ringo  
Anaesthetic (Primary) General Anaesthetic  
Appointment Date 17/02/2025 Time 09:00 Adm # 715  
Appointment Type Standard 30 Make Recurring Mins 30  
Procedure Notes Left Knee Arthroscopy  
Other Notes  
 OEC Received  OEC Checked  Pre-Admission Contacted  
 IFC Completed  Admission Form Received  Chart Ready  
 Consent Received  Post-Discharge Contacted  Documents Scanned  
 Patient Category Low Only Start at Day 1 Discharge 0  
 Accom Type Accom - Medical Room Type Private  
 Provisional DRG Program Status Start Select Epo...  
 Bed Notes  
 Cancelled Confirmed Arrived Time  
 Booking Code 1 Booking Code 2  
 Food Instructions

For example, the automated SMS feature will check for appointments scheduled in the next two days that haven't been confirmed. It will send the selected SMS template at 9am.

For the below example, let's say today is Monday:

- The system will check all appointments scheduled for Wednesday and send the SMS to those without an entry in the **Confirmed** field.
- FYDO will also scan for any late additions to appointments within the two-day window to ensure these patients also receive the SMS.

### SMS Automation

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**Condition**  
To Confirm Appointment ▼

**Template**  
Pre-Admission Text ▼

**Days Before** 2 **Send At** 09:00 AM

**Location** Shaes Private Hospital ▼ **Doctor/Theatre** All Theatres ▼

## Post Discharge

This SMS automation is based on the **Discharge Date**. Once an episode is discharged, the SMS will be sent at the designated timeframe **after** the discharge date.

For example, if today is Monday and a patient is discharged at 1pm, they will receive the automated **Post Discharge SMS** one day after their discharge date. In this case, the SMS will be sent on Tuesday at 9am.

### SMS Automation

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**Condition**  
Post Discharge ▼

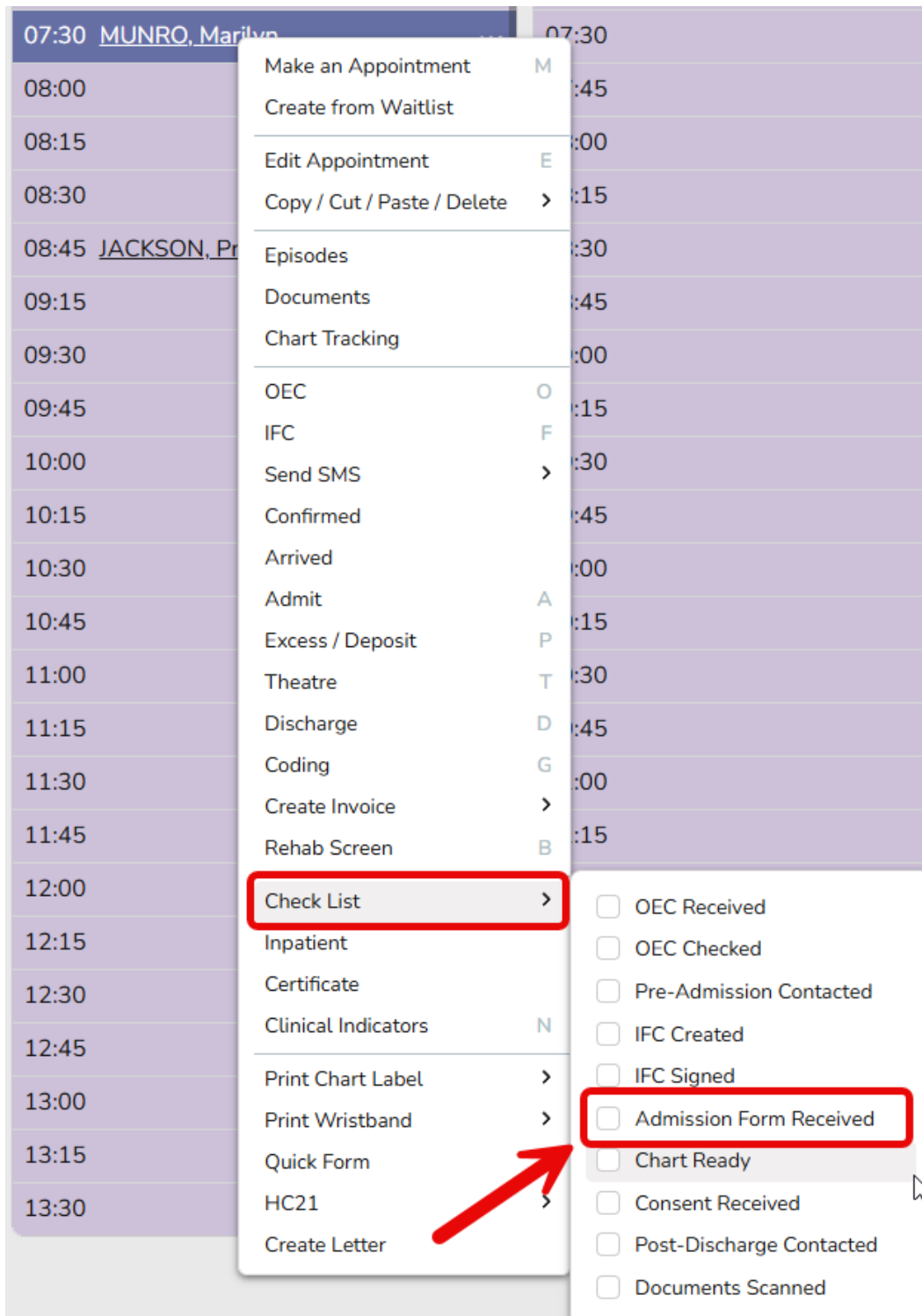
**Template**  
Post-Operative Message ▼

**Days After** 1 **Send At** 09:00 AM

**Location** Shaes Private Hospital ▼ **Doctor/Theatre** All Theatres ▼

# Admission Form Not Received

This automated SMS is triggered based on the **Admission Form Received** Check List item. If the checkbox is marked for a patient's admission, they will not receive the automated SMS. This means the SMS will only be sent to patients who have not yet completed their admission form!



With the check box now automatically ticked when patients completed Online Preadmit Paperwork is committed, following up with patients who still need to complete this task has never been easier!

For the below example, if a patient is booked for Monday, they will receive their **Admission Form Not Received** reminder on Sunday at 8am, the day before their scheduled admission.

## SMS Automation

**Condition**  
Admission Form Not Received

**Template**  
Preadmit Paperwork Reminder

**Days Before**  
1

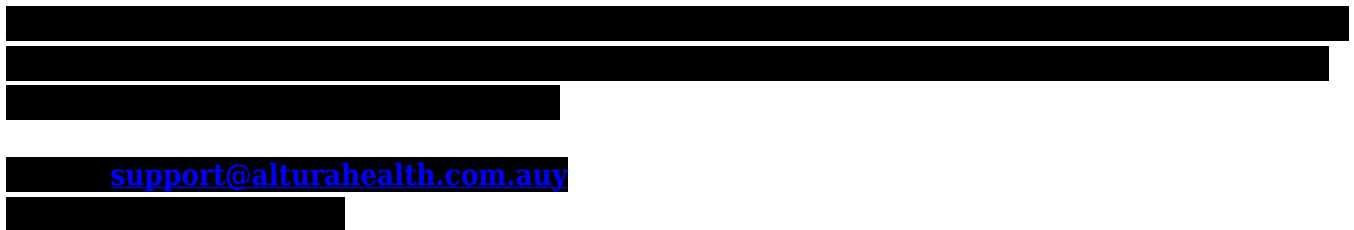
**Send At**  
08:00 AM

**Location**  
Shaes Private Hospital

**Doctor/Theatre**  
All Theatres

Cancel Setup Auto SMS

Keep in mind, you can set up **multiple SMS Automations!** So, if you want to remind patients every day until they submit their admission form, you can easily do that!



Let's look at a demo setup for streamlining patient communication! Automating these SMS reminders can really help improve patient engagement and reduce the administrative burden on staff. Here's an example of how it can work and why it's effective:

Condition	Template	Days After/Before	Send At	Location	Doctor/Theatre	Action
Admission Form Not Received	Preadmit Paperwork	4	9:00 AM	Shaes Private Hospital	All	...
Admission Form Not Received	Preadmit Paperwork Reminder	2	10:00 AM	Shaes Private Hospital	All	...
To Confirm Appointment	Pre-Admission Text	1	8:30 AM	Shaes Private Hospital	All	...
Post Discharge	Post-Operative Message	1	9:30 AM	Shaes Private Hospital	All	...
Post Discharge	Patient Survey	5	8:00 AM	Shaes Private Hospital	All	...

100 Records/Page Records 1-5 of 5 (Page 1 of 1)

### 1. Online Pre-Admission Form Link (4 days before admission)

This gives patients a head start in completing their required paperwork. The fact that it only contacts those who haven't already submitted the form is a great way to avoid unnecessary follow-ups and potential annoyance for patients who are already on top of their forms.

### 2. Follow-Up Reminder for Admission Forms (2 days before admission)

A reminder just before the deadline to submit the form ensures that those who missed the first notification get another nudge, but again, it avoids bothering anyone who's already completed the form. A gentle follow-up can help improve compliance.

### 3. **Pre-Procedure Confirmation (1 day before admission)**

This is crucial for making sure patients are prepared with all the details - admission time, fasting instructions, what to do when they arrive, and appointment confirmation. It helps patients feel more confident and organized the day before their procedure.

### 4. **Post-Discharge Check-In (1 day after discharge)**

Checking in on patients after they leave the hospital can show that you care about their recovery, making them feel supported and giving you an opportunity to catch any concerns early. Helping you meet your post-discharge obligations.

### 5. **Patient Survey Link (5 days post-discharge)**

Asking for feedback via a patient survey is a great way to gather insights on their experience and identify any areas for improvement. Giving them a little time to settle into their recovery before asking for feedback might result in more thoughtful responses. Automating this follow up ensures all patients are given the opportunity to participate in providing feedback.

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## Claims Import - Returned Files

To save time double reconciling payments, FYDO can produce a file with the exceptions and payment data, so that it can be imported back into your main system.

We can produce these files in XML format.

**Note** - nothing is returned back for Patient Claims.

## Exception Statement

### XML

Each item is export in the exception file, not just items that were rejected or paid a different amount.

- Batch Number
- External Servicing Dr Id
- Claim Date
- Total Paid i.e. for the entire batch
- Voucher/Invoice Information
  - Id
    - VVSS, the first 2 digits (VV) represent the voucher position within a batch and the next 2 digits (SS) represent the service position within the voucher
  - External Patient Id
  - External Invoice Id
  - Patient Surname
  - Patient First name
  - Patient Medicare Number

- Medicare Flag
  - A - Patient identification has been amended
  - I - Patient medicare issue number changed
  - C - Patient medicare number changed
  - W - Patient card used will expire shortly
  - S - Patient card expired. Future services may be rejected
  - X - Old Medicare issue number for patient. Future services may be rejected
  - empty - no change
  
- Veterans Number
- Veterans Flag
  - A - Patient identification has been amended
  - C - Patient veterans number change
  - empty - no change
  
- Item Number
- Date of Service
- Amount Paid
- Exception Code
- Explanation Text
- Medicare Benefit (only provided when an ECLIPSE claim)
- Health Fund Benefit (only provided when an ECLIPSE claim)
- Health Fund Exception Code (only provided when an ECLIPSE claim)
- Health Fund Explanation Text (only provided when an ECLIPSE claim)

## Payment File

### XML

- Batch Number
- External Servicing Dr Id
- Claim Date
- Total Claim Amount Paid
- Run Date
- Run Number
- Voucher Information
  - Id
    - VVSS, the first 2 digits (VV) represent the voucher position within a batch and the next 2 digits (SS) represent the service position within the voucher

- External Patient Id
- External Invoice Id
- Patient Surname
- Patient First Name
- item Number
- Date of Service
- Amount Paid

## Notes

**External Doctor ID / External Patient ID / External Invoice ID** - As long as this was provided when the data was imported, then we can include this when these export files are created.

## Sample File