

How to Create a Manual Clinic Invoice

From time to time, you may need to bill a *manual invoice*. Other terms for this type of invoice include: *private invoice* or *paper based invoice*.

When would you need to bill a manual invoice? In the event a patient is a private patient and thus will be paying for services rendered directly. Or perhaps when the patient does not have medicare entitlements (such as overseas patients) and the invoice will need to be sent to their health insurance. Additionally, you may need to send the health funds a manual invoice where manual assessment is required; such as when you are seeking an adjustment.

Now that you know when you'd need to create a manual invoice, let's jump right into it.

Start off by opening the patient's record and click on the blue "**Bill Patient**" button.



You can also use the hotkey 'B'!

This will take you to the **Clinical Billing** page, where you'll need to select the:

- **Location:** the location where the service took place. If you only have one, it will be defaulted
- **Practitioner:** the practitioner who performed the service. If you only have one, it will be defaulted
- **DOS:** date of service
- **Bill Type:** Private
- **Type:** '**Patient**' If the invoice is being sent to the patient, or '**Health Fund**' - If the invoice is being sent to the patient's Health Fund

MRN 117

Patient BURDETTE, Pamela

Location

Eccles

Practitioner

CELES, Peter

DOS

29/12/2020



In Hospital

Hospital

Bill Type

Private

Type

Patient

Fee Level

Level 3 - BUPA

Employer

E

Health Fund

H

Other

O

Patient

P

Referral

Referrals

The last step before we can begin billing is to enter any needed referral information. If this does not apply to you, click on **Add Items** and proceed to the next section.

Otherwise, simply fill out the **Referral** section as seen below. If you only have one referring doctor for this patient, they will be automatically selected here (provided it has not expired).

Referral

Referral Flag

Previous Referrals

Referring Doctor

ADD REFERRING DOCTOR

Referral To

TESTER, Marko x

TESTER, Dr Bill x

Referral Date

19/05/2020



Period

12

First Consult



Site Referral (global)

ADD ANOTHER REFERRAL

Once you are done with the above segments, click on the green **Add Items** button in the bottom left corner of your screen.

Add Items

You will arrive at the **Clinic Billing** page. Here we can see a brief overview of previous information for the patient, and where we can bill an invoice.

It is as easy as typing in the item you need and selecting it. There are two different ways to search for the item as shown below:

- **Search for the item number itself.**
- **Search for a word in the description.** This can either be at the start, or anywhere within the description!

DOS	Item	Description
17/08/2020	I	

Once you have entered all your items and payments as desired, click on the **Review Charges** button to proceed to the final page of billing.

[Review Charges](#)

(Conditional) Applying Payment *at* the billing process

If the patient is paying the invoice, you can add payments captured from the patient onto the invoice using the **Add Payment** button.

Otherwise, if you are sending the invoice elsewhere to be paid. Skip this step for now and proceed to **'Clinic Review Charges'**. You will be able to add payment against the invoice later, once it is paid.

[Add Payment](#)

The above button will present you with a pop-up to enter the payment information. The total invoice amount will be prefilled in the **Amount** field.

So, you may simply allocate the payment type and hit save as below:

Payment

Accounting Period: 17/08/2020

Type: [dropdown]

Amount: 196.70 [Apply Gap](#)

Drawer: BAKERR, Maryrose

Reference: [empty]

Bank: [empty]

Branch: [empty]

Save Cancel

Clinic Review Charges

You may notice that this page looks nearly identical to the previous **Clinic Billing** page. The only real difference is that you can no longer add or change items, and there are additional buttons at the bottom.

You will also be able to see the **Total Charges** for the items you have billed like so:

Total Charges	\$196.70	Total GST	\$0.00
Total Rebate	\$173.05	Out of Pocket	\$23.65

Lets go over the options on this screen:

[Edit Item And Charges](#)

Cancel

Save

Save & Print

Edit Item And Charges: Realised you have made a mistake? Click this button to go back to the previous page and fix it up!

Cancel: Cancel out of this billing. This will take you back to the **Patient Screen**.

Save: Saves this invoice.

Save & Print: this saves and prints the invoice.

That's it! You've successfully created a manual invoice; and if you've paid it off on the spot, there is nothing else that you need to do.

Otherwise, assuming you've sent the invoice to a health fund, you will need to follow up with them every couple of weeks to see whether or not it is paid. Once it is paid, follow the steps below to pay it off on FYDO.

Applying manual payments

Your manual invoice is paid now? [Click here to learn how to apply a manual payment to it.](#)

Resubmitting and Deleting Clinic Batches

Sometimes you may need to **Resubmit** or **Delete** a batch depending on rejections.

You will only be able to move or delete a batch if the invoices within do not have payments

Resubmitting a Batch

To Resubmit a Batch you will first have to move each **invoice** within to a new batch. We can then go ahead and send that new batch.

1. View the batch in question so you can see the invoices within
2. Right click and select '**Move Invoice Out**'
3. Confirm the move

Patient Name ↓	MRN	DOS ↓	Inv	KG	Claimed	Items
CAREY, Mariah	107	30/12/2020	89		173.05	2
CAREY, Mariah	107	30/12/2020	92		38.75	1

If you head back to **Claiming Medical**, you will now notice a new batch that contains any invoices that were moved. Simply follow the usual process for closing and sending this batch.

For Eclipse claims, you will still only be able to have one patient per batch.

Deleting a Batch

To Delete a Batch, you will have to either **move** or **delete** each invoice within. Then the batch will simply disappear.

1. View the batch so you can see the invoices within
2. Right click and select '**Delete Invoice**'
3. Provide a reason and select **Delete**

This is an internal reason just for your future reference.



Patient Name ↓	MRN	DOS ↓	Inv	KG	Claimed	Items
CAREY, Mariah	107	30/12/2020	89		173.05	2

You can also use **Reverse**. This produces an adjustment against the invoice, rather than just deleting it.

Rejected Clinic Batches

Once you have done some billings, you may notice that payments have come back for a lower amount, or perhaps you have received no payment at all!

Identifying batches with issues

The easiest way to spot if a batch had an issue, is to simply look at the **Paid** column. If you see any amount in **Red**, then some action will be required.


Claimed	Status	KG	Paid	PaidDate
43.60	Processed		33.50	
63.25	Processed		63.25	
63.70	Processed		63.70	
63.70	Processed		63.70	
41.55	Processed		41.55	
43.60	Processed		0.00	
43.60	Processed		0.00	
63.25	Processed		63.25	
66.35	Processed		51.00	

We can see in the image above, that we have two batches that are **partially paid** (Less than what we claimed). We also have two batches that are just **Rejected** (\$0.00 Paid).

Dealing with the Batches

First, double click on the batch to view inside. You can also right click and select **View Batch Details** if you prefer.

Once you can see a list of patients within a batch, the thing to keep an eye out for is an icon in the **Issue** column.

Claimed	Items	Issue	IH	Note
43.60	1		Y	

You may have one, or multiple patients with an issue. Any patient with a **Rejection** or **Partial Payment** will have the above icon.

Viewing the Rejection Reason

Now that we have identified which patient(s) have an issue. It's time to see what the issue actually is.

Again, lets double click on a patient, or using the right click menu, select **View Items**.

Payable	MedExc	MedPay	FundExc	FundPay
0.00	999 - Missing exception code from exception statement	0.00	2001 NO HOSPITAL CLAIM (PEA)	0.00

In the above case, this is a fairly easy rejection to identify the issue. We have the error code **2001 No Hospital Claim (PEA)**. From this we can deduce that the hospital has not submitted their invoice yet, and as such we cannot be paid. Our options are to just wait and try to resubmit, or you could confirm with the hospital when they are sending their claim.

One of the most common issues is that you have been paid a different amount to what you claimed. This could happen for a number of reasons such as:

- Fee Changes by Medicare/Health Funds
- Doctors agreement with a fund
- Old date of Service

Charge inc GST	GST	Payable
66.35	0	51.00
<input type="checkbox"/> GST applicable		

To amend this, simply right click on the item and select **Edit**. Alternatively use the hotkey 'E'. Then just alter the **Charge inc GST** to be equal to the **Payable** amount, as shown above.

Contacts

Not all rejections will be as simple as the ones above. In a case where you are not sure what a rejection reason means, or why something has not been paid, it is best to contact the organisation who rejected it.

We have a [complete list of phone and email](#) for medicare and the health funds.

[How to create a referral](#)

If needing referrals applies to your discipline, read on to learn how to create new referring doctors on your FYDO system; and how to create referrals on patient records.

Start off by opening a patient's record. Below is an example of a patient record, with the referral section highlighted.

117 - BURDETTE, Pamela

Patient Details	Other	Appointments	Recalls	Accounts	Episodes	Communication
-----------------	-------	--------------	---------	----------	----------	---------------

Patient Details

Patient #	117	File Num		External ID	117
Title	Mrs	Gender	Female		
First Name	Pamela			Mi	
Last Name	BURDETTE				
Pref. Name					
Address	1 Scotts st				
Suburb	KILLARA	State	NSW	Postcode	2071
Mailing Address					
Suburb		State		Postcode	
Date of Birth	01/01/1920	Age	100	DOB Estimate	<input type="checkbox"/>
Mobile	0423-555-552	Home	() -	Work	() -
Email	pamela@gmail.com				

Medicare/DVA Details

Medicare Number	2111-11111-1	Ref	1	Exp	
Eligibility	Eligible - Australian Resident				
Veterans No.		Veteran Card Colour			
DVA Auth.No		DVA Auth. Date			
Entitlement Card			Exp		

Referring Details

Previous Referrals					
Referring Doctor					
Referral Date		Period		First Consult	
Referral To					
	<input type="checkbox"/> Site Referral (global)				

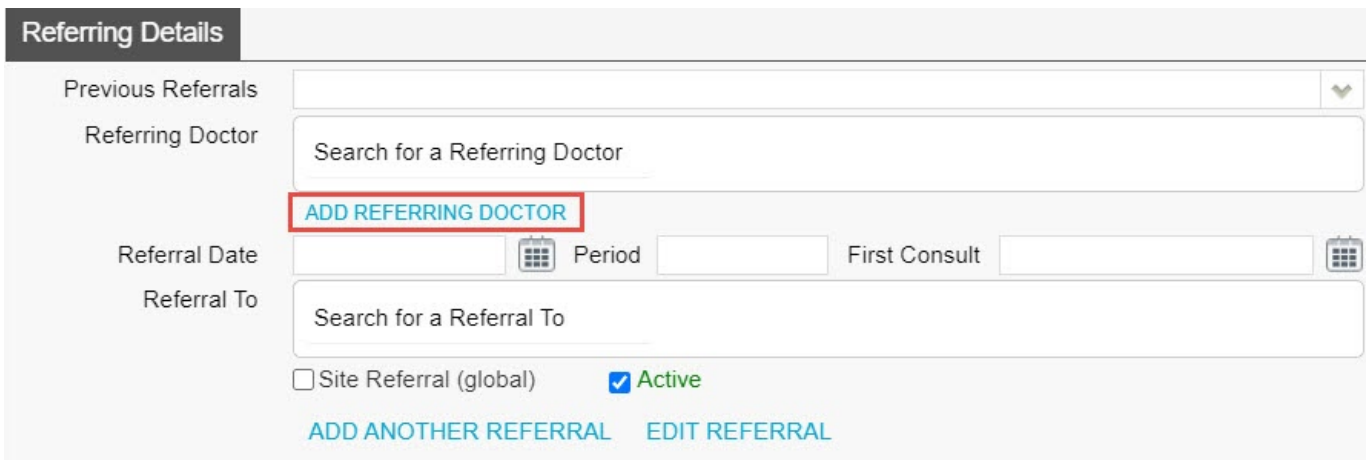
Notice that the data fields on the record are greyed out and you cannot commit any changes. This is because you are not in *edit mode* and therefore cannot make any edits.

So click on the **Edit** button to continue.

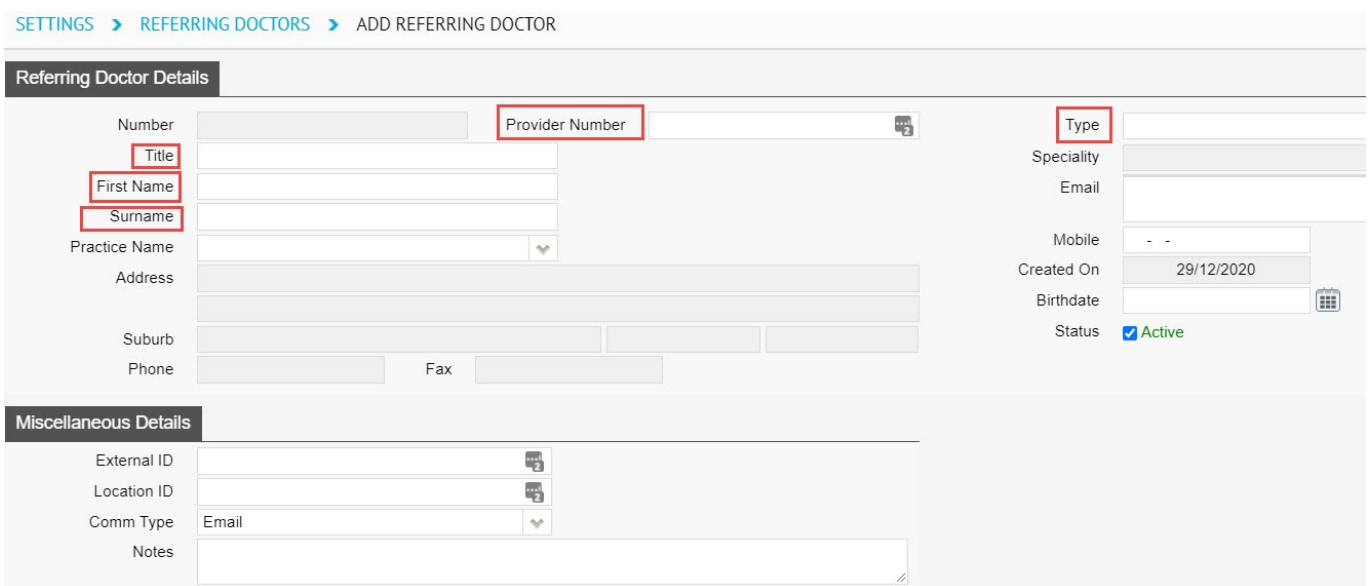


You will now be able to make edits to this record, scroll down to the **Referring Details** section.

If the referring doctor has never been entered into your FYDO system, click on the blue **ADD REFERRING DOCTOR** button to add a *NEW* referring doctor.

A form titled "Referring Details" with a dark header. It contains several input fields: "Previous Referrals" (dropdown), "Referring Doctor" (search field), "Referral Date" (calendar icon), "Period" (input), "First Consult" (calendar icon), and "Referral To" (search field). There are checkboxes for "Site Referral (global)" and "Active" (checked). At the bottom, there are two blue buttons: "ADD ANOTHER REFERRAL" and "EDIT REFERRAL". A red box highlights the "ADD REFERRING DOCTOR" button.

This will present you with the below screen, where the main data fields are highlighted. So go ahead and fill this in along with any other additional information you'd like to store about this referring doctor.

A form titled "ADD REFERRING DOCTOR" with a breadcrumb trail: "SETTINGS > REFERRING DOCTORS > ADD REFERRING DOCTOR". The form is divided into two sections: "Referring Doctor Details" and "Miscellaneous Details". The "Referring Doctor Details" section has fields for "Number", "Title", "First Name", "Surname", "Practice Name", "Address", "Suburb", "Phone", "Fax", "Provider Number", "Type", "Speciality", "Email", "Mobile", "Created On" (29/12/2020), "Birthdate", and "Status" (checked "Active"). The "Miscellaneous Details" section has fields for "External ID", "Location ID", "Comm Type", and "Notes". Red boxes highlight the "Title", "First Name", "Surname", "Provider Number", and "Type" fields.

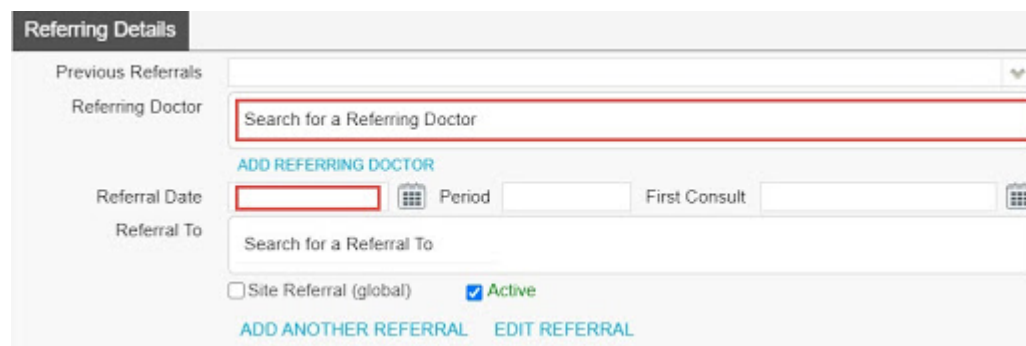
Note: this only needs to be done **once** per referring doctor.

Referring doctor 'Type'

- **GP:** by default, GP referrals have a referral period of 12 months
- **Specialist:** by default, Specialist referrals have a referral period of 3 months

If the referring doctor has already been entered into FYDO as a referrer, you will be able to search for them by clicking on the search box pictured below. You may search by the doctor's first or last name.

Next, enter the **Referral Date** and you're done! This is the minimum data set for adding a referral to a patient's record.



The screenshot shows the 'Referring Details' form. It has a dark header with the text 'Referring Details'. Below the header, there are several sections: 'Previous Referrals' with a dropdown arrow; 'Referring Doctor' with a search box containing the text 'Search for a Referring Doctor' and a blue button labeled 'ADD REFERRING DOCTOR'; 'Referral Date' with a search box, a calendar icon, and a 'Period' field; 'First Consult' with a search box and a calendar icon; 'Referral To' with a search box containing the text 'Search for a Referral To'; and a section with two checkboxes: 'Site Referral (global)' (unchecked) and 'Active' (checked). At the bottom, there are two blue buttons: 'ADD ANOTHER REFERRAL' and 'EDIT REFERRAL'.

Notes on other data fields in 'Referring Details'

- **Period:** this is how many months the referral is valid for. It may be overwritten by the user, at their discretion
- **First consult:** if the first *Date of Service* is after the *Referral Date*, you may enter the date of service into this field so that the *Referral Period* is calculated from this date, rather than the referral date
- **Referral to:** this is which provider the referral is for. If left blank, upon billing it will get linked to that provider;
- **Site Referral (global):** allows this referral to be used by any provider rather than one specific provider.

That's it! You've added a new referring doctor to your FYDO system and created a referral on a patient's record. Click on the green **Save** button on the top right corner of the patient record to save your changes.

Save

Editing, deleting, and inactivating referrals

Made a mistake when creating the referral? No problem. Read on to see how to edit or delete referrals.

Start off by opening a patient's record. Below is an example of the referral section of a patient's record.

Referring Details + ✎ 🗑️

Previous Referrals ▼

Referring Doctor Add Referring Doctor Referral To

SMITH, John x Search for a Referral To

Referral Date	Period	First Consult	Site Referral (global)	Open Access	Status
01/12/2025 📅	12	📅	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Active

- **Add another referral:** FYDO allows you to have multiple referrals for a given patient. Use this button to add another referral
- **Edit referral:** this button allows you to make changes to any of the data fields of a given referral
- **Delete this referral:** this button will remove the referral
- **Active:** untick this checkbox to make the referral inactive

Results of an OEC

If you have not submitted an OEC yet, please see our guide found [here](#)

To find your **OEC**, first access the **Documents** from the patients record.

Patient Details Appointments Recalls Accounts Episodes Communication Chart Tracking **Documents** Clinical

You will see a list of all the recorded documents for this patient. The **OEC's** that were returned will

have the **Name** and **Type** of **OEC**. The MBS item number the OEC was ran on will also be included in the OEC name, eg; OEC-39323. Select one to view. These documents can be printed or downloaded as needed but will always be kept here, within the patient record.

Admission Form_001	Admission Form	08/01/2026	05/01/2026	Q ...
IFC 2026-01-05	IFC	08/01/2026	05/01/2026	Q ...
OEC-39323	OEC	08/01/2026	05/01/2026	Q ...
OEC-39323	OEC	08/01/2026	05/01/2026	Q ...
OEC-39323	OEC	08/01/2026	05/01/2026	Q ...
OEC-61109	OEC	08/01/2026	05/01/2026	Q ...
IFC 2025-12-22	IFC	08/01/2026	22/12/2025	Q ...

The first part of your **OEC** contains some patient information, as well as the **Fund** status on the check. It will also show the **Explanation**, on our **OEC** below we can see that the patient is eligible, but subject to conditions. The conditions will need to be confirmed with the fund:

Patient Name	[REDACTED]	MRN	674
Fund / UPI	TFH [REDACTED]	DOB	[REDACTED]
Transaction ID	ADV021982e4cb6df24fb43c1	Gender	[REDACTED]
Requested	12/11/2025 09:48 AM	OEC Type/ID	ECF / 1272
Medicare Status	-	Fund Status	0 - Patient is known to the Health Fund specified in the request.
Assessment	WARNING	Process	COMPLETE
Explanation	1102 Eligible Subject to Conditions		

Health Fund Assessment

The next part of the **OEC** details the patients financial eligibility. We can see any **Excess** or **Co Payments** that are applicable, as well as a description of what the patients cover is limited to. Any **Excess** shown here will be automatically updated in the **Appointments** screen for this patient.

Health Fund Assessment

Excess \$ 500.00	Description	Capped each calendar year at once per adult when amount has been met in full. The excess does not apply on admissions for services with a minimum benefit, approved hospital ambulatory programs or to approved psychiatric and rehabilitation day programs in private hospitals only. Excess will apply for all overnight and day services in private and public hospitals. The excess does not apply to any child dependant covered on the membership.	Bonus	\$ 0
Co Payment \$	Description	Co-payment not Applicable	Remaining Days	

Just below the excess and co payment information, you will find the final details of the **OEC**. The fund will detail the members cover and the description will mention services that are excluded. There is also space for **Benefit Limitations** and **Exclusions**. If your **OEC** shows the patient as not having cover, these fields will detail what the exclusions are and why the patient is not covered.

Health Fund Ref	1501371
Table Name	Silver Plus Hospital \$500 Excess
Table Description	SILVER PLUS **All hospitals** : Excluded Services: Pregnancy and birth; Assisted reproductive services; Weight loss surgery; Laser eye correction; Cosmetic surgery receive no benefits. Minimum Benefit (Restricted cover) shared room rate for Podiatric surgery for accommodation. If Minimum Benefits shared room rate is paid, excess is not deducted. **Members First Network Hospitals** : Cover for hospital accommodation theatre fees for services that are not Excluded or Minimum Benefit services. **Public Hospitals** : Minimum Benefits for shared room accommodation as set by the Australian Government plus fixed benefit per day for private overnight room accommodation. Special Benefits that help pay for certain in-hospital parent/partner accommodation and meals are included. Minimum Benefit services are not eligible for private room benefits. Excess does not apply for children.
Table Scale	SINGLE
Benefit Limitations Exclusions	

Finally, there is a field for any **Other Services** that were checked, such as **Prosthesis** items.

Items and Other Services

Type	Code	Charge	Fund Assess	Fund Amt	Med Assess	Med Amt

[How to Bill Patient Clinic Claims](#)

Ready to bill through the **Patient Claims** billing channel? Follow along to learn how.

Need to learn more about Patient Claims first? [Click here](#) for more.

To get started, from the **Patient Record**, we are going to click on the **Bill Patient** button.

Bill Patient

You can also use the hotkey 'B'!

This will take you to the **Clinical Billing** page, where you'll need to select the:

- **Location:** the location where the service took place. If you only have one, it will be defaulted
- **Practitioner:** the practitioner who performed the service. If you only have one, it will be defaulted
- **DOS:** date of service
- **Bill Type:** Patient Claims
- **Type:** 'Store & Forward', or 'Real Time' - more on this below

The screenshot shows a form with the following fields and values:

- Location: Eccles
- Practitioner: CHANDRA, Pete
- DOS: 17/08/2020
- Hospital: (empty)
- Bill Type: Patient Claims
- Fee Level: Level 1 - MBS
- Type: Real Time (RT)

A red box highlights the Bill Type and Type fields. A red speech bubble with the word "Required" points to the Type field.

Store & Forward vs Real Time

The primary difference between these two types of Patient Claims is that:

- With **Real Time**, your invoices are sent to Medicare *in real time, as they are created*. That is, they do not go into a batch that you then manually send off at the end of the day. They do end up in a batch however.
- Whereas with **Store & Forward**, invoices enter a batch for later transmission. This is how all other Bill Types such as Eclipse, Medicare, and DVA behave.

Some things to note about Real Time

- Should you need to delete an invoice after creating it, you have until the close of business that day to delete it, via the software. This is called '**Same Day Delete**'

- However, if you realise you need to delete an invoice the next day or later, you will now need to contact Medicare and ask them to delete/ ignore the invoice on their end
 - If you realise you need to delete an invoice and it has already been paid, again, you will need to contact Medicare and process a refund.

Referrals

The last step before we can begin billing is to enter any needed referral information. If this does not apply to you, click on **Add Items** and proceed to the next section.

Otherwise, simply fill out the **Referral** section as seen below. If you only have one referring doctor for this patient, they will be automatically selected here (provided it has not expired).

Referral

Referral Flag

Previous Referrals

Referring Doctor

TESTER, Marko x

ADD REFERRING DOCTOR

Referral To

TESTER, Dr Bill x

Referral Date

19/05/2020

Period

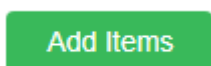
12

First Consult

Site Referral (global)

ADD ANOTHER REFERRAL


Once you are done with the above segments, click on the green **Add Items** button in the bottom left corner of your screen.



You will arrive at the **Clinic Billing** page. Here we can see a brief overview of previous information for the patient, and where we can bill an invoice.

It is as easy as typing in the item you need and selecting it. There are two different ways to search for the item as shown below:

- **Search for the item number itself.**
- **Search for a word in the description. This can either be at the start, or anywhere within the description!**

DOS	Item	Description
17/08/2020 	I	

Notice that for **Patient Claims**, the **Date of Service (DOS)** can be changed in an invoice.

Applying Payment

Once you have added all your desired items, you can add payments captured from the patient onto the invoice using the **Add Payment** button.



This will present you with a pop-up to enter the payment information. The total invoice amount will be prefilled in the **Amount** field.

So, you may simply allocate the payment type and hit save as below:

Payment
X

Accounting Period	<input type="text" value="17/08/2020"/>		
Type	<input type="text"/>		
Amount	<input type="text" value="196.70"/>		Apply Gap
Drawer	<input type="text" value="BAKERR, Maryrose"/>		
Reference	<input type="text"/>		
Bank	<input type="text"/>		
Branch	<input type="text"/>		

Save
Cancel

Once you have entered all your items and payments as desired, click on the **Review Charges** button to proceed to the final page of billing.

Review Charges

Clinic Review Charges

You may notice that this page looks nearly identical to the previous **Clinic Billing** page. The only real difference is that you can no longer add or change items, and there are additional buttons at the bottom.

You will also be able to see the **Total Charges** for the items you have billed like so:

Total Charges	\$196.70	Total GST	\$0.00
Total Rebate	\$173.05	Out of Pocket	\$23.65

Lets go over the options on this screen:

[Edit Item And Charges](#)

Cancel

Save

Save & Print

Edit Item And Charges: Realised you have made a mistake? click this button to go back to the previous page and fix it up!

Cancel: Cancel out of this billing. This will take you back to the **Patient Screen**.

Save: Save this invoice, send it to the **Claiming Medical** section, ready to send.

If **Save & Print** is selected, it will also be printed.

You're all done! You have successfully billed a Patient Claims invoice. Now, head over to '**Claiming Medical**' and send it off.

Not sure how to send off your claims? [Click here](#) for more on Claiming Medical.

[What is Patient Claims \(Clinic\)](#)

In a nutshell

Patient claims is where the practice sends off the patient's claim on their behalf so that they can **receive their medicare rebate** 1-2 business days later. The patient could pay in full, partially, or nothing at all.

You would use this claiming channel when the practitioner charges above the medicare schedule. You would not use this claiming channel if you are happy to receive the medicare/bulk bill amount.

This claiming channel is useful because whilst it would be easier to bulk bill the patient, and then charge a copayment, this is illegal.

Patient Claims is desirable for the practice because:

- The practice may be **paid in full, on the spot**
- The practice decides what they would like to charge
- Multiple dates of service **per invoice** supported
- May avoid the **90 day scheme**, more on this below

90 day scheme

When an unpaid or partially paid claim is sent to medicare, the patient receives a Pay Doctor Via

Claimant (PDVC) cheque and they are expected to forward this cheque to the practitioner.

- The cheque will be in the the doctor’s name, so the patient cannot bank this money
- The 90 day scheme is a measure in place to redirect the funds directly into the doctor’s bank account, in the event that the cheque is not banked by the doctor within 90 days
- However, this is only eligible for gps and specialists, and is not applicable to allied health practitioners

Eligible health professionals

Eligible health professionals	Lodge claims manually	Need to register for scheme
GP	Yes	Yes
Specialist or consultant physician	Not eligible	No

Eligible health professionals	Lodge claims electronically	Automatically eligible for scheme
GP	Yes	Yes
Specialist, consultant physician, pathologist	Yes	Yes

Ineligible practitioners

Allied health professionals, optometrists and dentists aren’t eligible to participate in the scheme.

Want to learn more about the 90 day scheme? [Click here](#) to read more.

Important note: for this billing channel, you will send claims, assuming they will get paid as no communications are sent back. This is owing to a Medicare limitation that only allows for one-way communication. That is, you can send claims but will not receive any:

- **Exception** statements, or
- **Payment** statements

Medicare Easyclaim

Easyclaim is another billing alternative for bulk billing and patient claims. It may be a stand-alone process via an EFTPOS machine or integrated into your billing software.

Note: FYDO does not currently support Easyclaim

Key features

- The patient receives their Medicare rebate almost immediately into their bank account
- No additional bank transaction fees. However, standard EFTPOS charges still apply
- May be used for bulk billing and patient claims
- Single payment made to practitioner's nominated bank account for bulk billed claims within 2-3 working days
- Concession verification - instant confirmation of patients' concessional status
- Available to all allied health professionals

Want to learn more about Medicare Easyclaim? [Click here](#) to learn more.

Ready to bill through the Patient Claims billing channel? [Click here](#) to learn how.

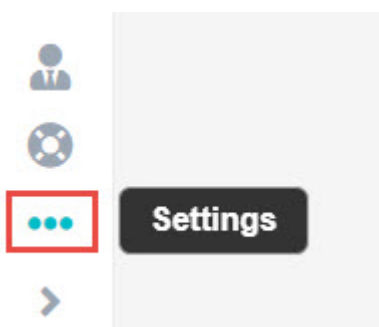
Health Fund Fees (Clinic)

Disclaimer: Altura Health recommends periodically checking these settings to ensure they are correct. Your fees will **not** update if these settings are incorrect. You are responsible for maintaining and ensuring these fees are set up correctly.

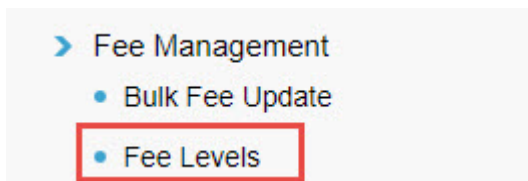
Tired of updating your Health Fund Fees every time a change occurs?

If Fydo is setup correctly, your health fund fees will automatically be updated! Simply follow this quick 5 minute guide, and never worry about your fees again!

First, lets head to **Settings**, found on the bottom left hand side of Fydo.



Then select **Fee Levels**, found underneath **Fee Management**



Fee Levels

You will now arrive at the **Fee Levels** settings. This page displays all of the current Fee Levels within Fydo, and lets you edit them as needed.

Now, lets select **Edit** from the top right hand corner of the page.



To setup automatic fee updates, we just need to change a few settings for each health fund.

- **Fund**
- **State (If Applicable)**
- **Fee Type (If Applicable)**

Level ↓	Description	Gap Amount	Threshold	Fund	State	Fee Type	Status
0	DVA In-hospital	0.00	01/11/2019				<input type="checkbox"/>
1	MBS 100%	0.00	01/11/2019				<input type="checkbox"/>
2	Workers Comp	0.00	01/11/2019				<input type="checkbox"/>
3	hcf no gap	0.00	01/07/2020	HCF		No Gap	<input checked="" type="checkbox"/>
4	hcf with gap	0.00	01/07/2020	HCF		Gap / Known Gap	<input checked="" type="checkbox"/>
5	ahsa nsw	0.00	01/07/2020	AHS	NSW		<input checked="" type="checkbox"/>
6	medibank	0.00	01/07/2020	MPL			<input checked="" type="checkbox"/>

Fund - This is a simple one, simply select the corresponding fund from the list. In the above case, I selected **HCF** for both of my HCF fee levels, **AHS** for my Alliance (AHSA) fee level and **MPL** for my Medibank Private level.

State - This will only apply to **Alliance (AHSA), BUPA and GU Health**. Select the state you require fees for. In the above case, I opted for the **NSW** fees.

Fee Type - This will only apply to **HCF and HBF**. Simply select if you need the **No Gap** or the **Known Gap** fees. In the above case, I have a fee level for both, though you may only have one.

Once you have completed the above, click the **Save** button.



All done! You can now rest easy, while we take care of the rest. Your Health Fund fees will automatically update as soon as we have the latest fees, usually every 2-3 months.

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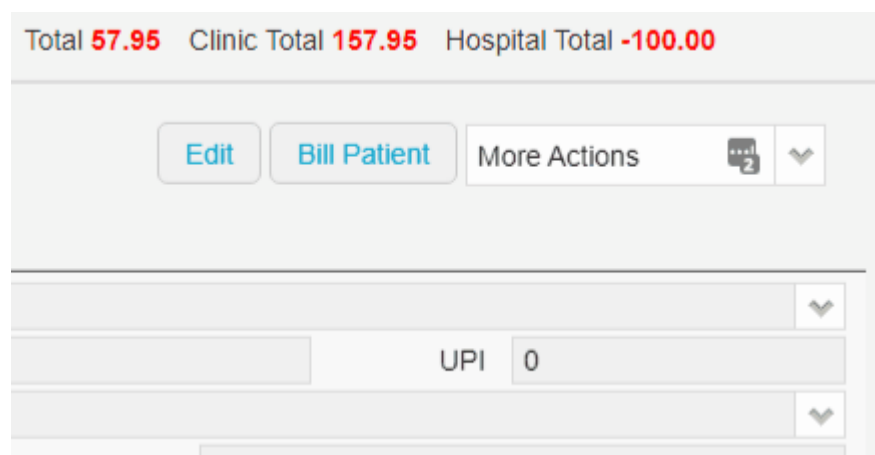
You can find the fees that Fydo will import [here](#).

[How to run a Clinic OEC - Online Eligibility Check](#)

There are two main ways to perform an **Online Eligibility Check (OEC)** for a patient.

Patient Record

Simply go the patient's record and under the '**More Actions**' select **Eligibility Check (OEC)**



Appointments

You can also access the **OEC** from Appointments (Hospital appointment), simply right click on an appointment and select **OEC**.

7:00 AM
8:00 AM
8:15 AM
8:30 AM
8:45 AM
9:00 AM
9:15 AM
9:30 AM
9:45 AM
10:00 AM
10:15 AM
10:30 AM
10:45 AM
11:00 AM
11:15 AM
11:30 AM
11:45 AM
12:00 PM
12:15 PM
12:30 PM
12:45 PM
1:00 PM
1:15 PM
1:30 PM
1:45 PM
2:00 PM
2:15 PM
2:30 PM
2:45 PM

You can also use the handy hotkey: **O**

OEC Request

The next step is to fill out the required fields in the **OEC request**.

Patient Details

The patient details will be automatically filled in by information taken from the patient's record such

as **Name, Fund, DOB, Membership Number, Medicare Number and Gender.**

Patient Details

First Name: Test	Surname: TEST	Middle Initial:	DOB: 01/01/1990	Gender: Male	Medicare: 2111-11111-1
Fund: ACA - ACA Health Benefits Fund	Membership: 344	UPI: 0	Claim Type:		

Eligibility Check

Like the **Patient Details**, the **Eligibility Check** fields are also pre filled from the patient record/booking. Things such as the **Admission Date, Hospital, Provider Number and Surgeon/Doctor.**

*The most common type of check you will be running will be **Fund Only.***

Eligibility Check

Type: ECF - Fund only	Adm Date: 14/04/2021	Dis Date: 14/04/2021	Same day
Hospital: Test Hospital	Provider Number: 002700Y	Surgeon/Admitting Dr: CITIZEN, John	Provider Number: 0
<input type="checkbox"/> Accident	<input type="checkbox"/> Emergency Admission	<input type="checkbox"/> Pre-existing Allment	<input type="checkbox"/> Compensation Claim

[Read Disclaimer](#)

Items

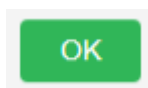
The final part of the **OEC** is to select the **Illness Code** or **MBS Items** to check. There are also **Protheses items** available to check. While the list of Illness Code's is comprehensive, it is generally more accurate to check if the patient is eligible for the items you will be billing.

Hospital Items

Illness Code: [?]

MBS Items			Other Services							
Item	Description	Action	Type	DOS	Code	Description	Unit Charge	Quantity	Total Charge	Action
[?]			Protheses	17/05/2021			1.00	1	1.00	

Now that the **OEC** is filled out, click **OK** to run it and we can take a look at the results.



To find out how to see the **OEC** results see our wiki page [here](#)