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

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

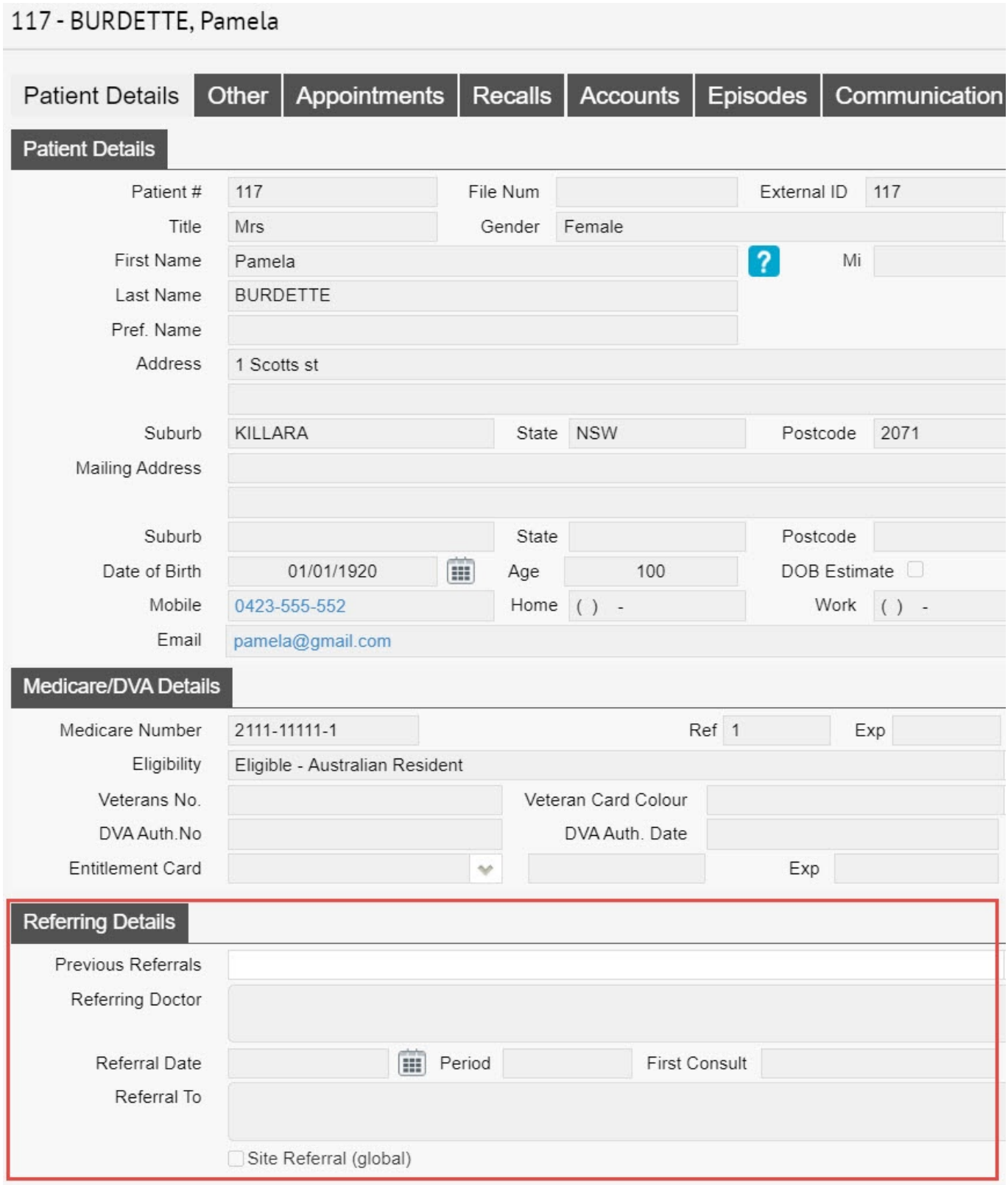
Not all rejections will be as simple as the ones above. In a case where you are not sure what a rejection reason means, or why something has not been paid, it is best to contact the organisation who rejected it.

We have a complete list of phone and email for medicare and the health funds.

How to create a referral

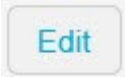
If needing referrals applies to your discipline, read on to learn how to create new referring doctors on your FYDO system; and how to create referrals on patient records.

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



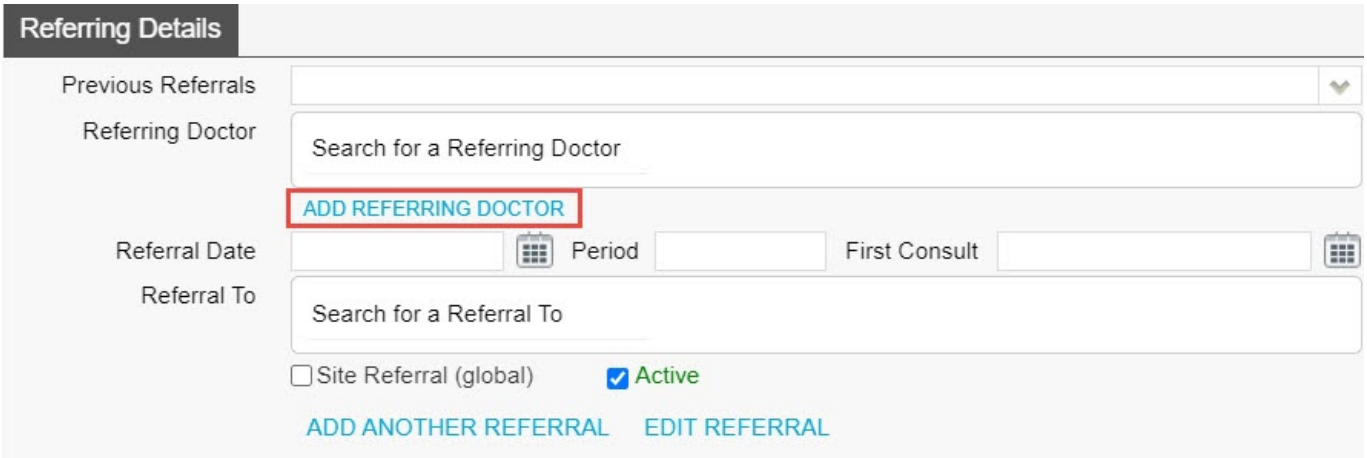
Notice that the data fields on the record are greyed out and you cannot commit any changes. This is because you are not in *edit mode* and therefore cannot make any edits.

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

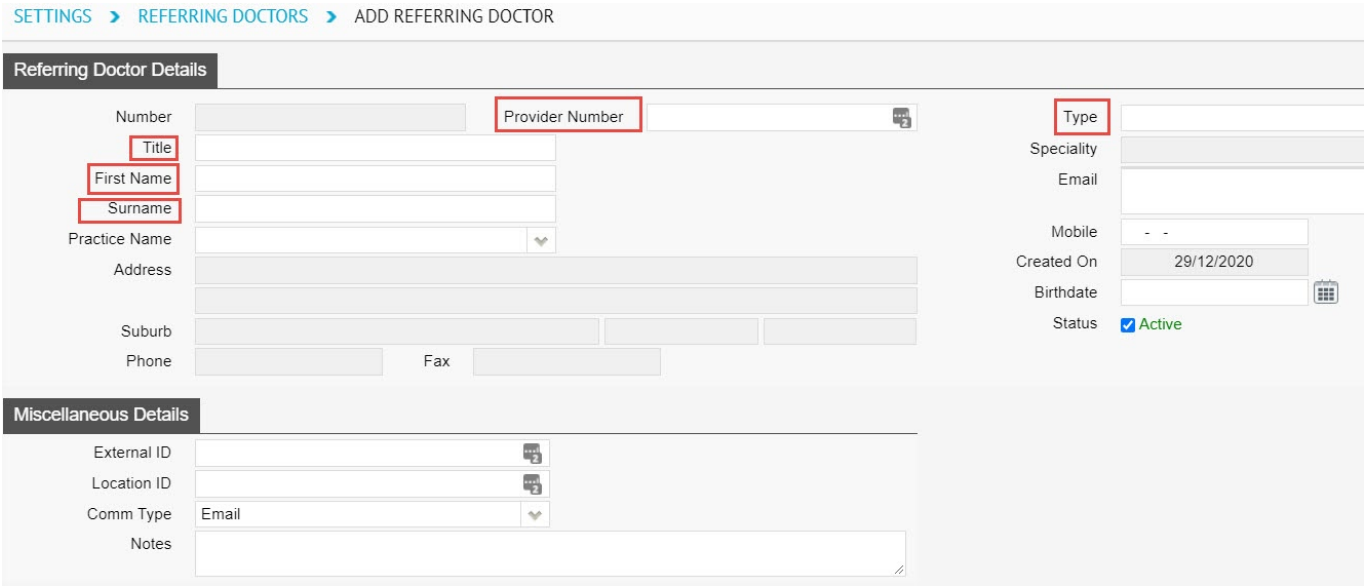


You will now be able to make edits to this record, scroll down to the **Referring Details** section.

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.



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.



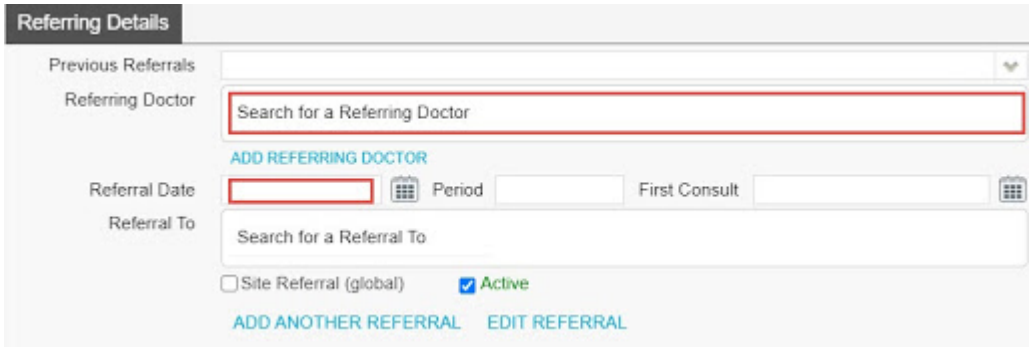
Note: this only needs to be done **once** per referring doctor.

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.



Notes on other data fields in 'Referring Details'

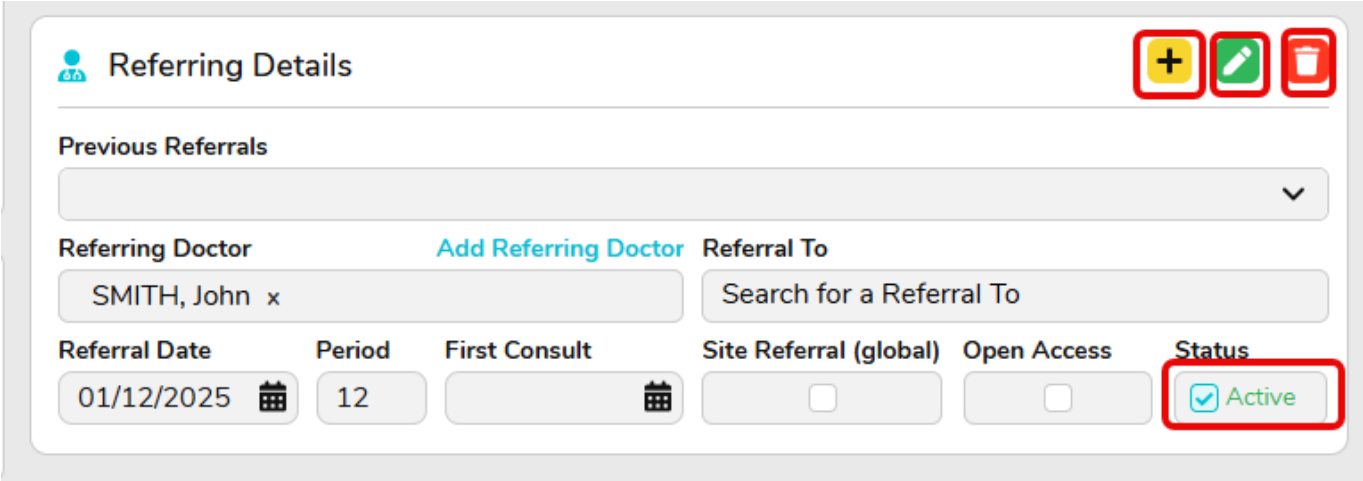
- **Period**: this is how many months the referral is valid for. It may be overwritten by the user, at their discretion
- **First consult**: if the first *Date of Service* is after the *Referral Date*, you may enter the date of service into this field so that the *Referral Period* is calculated from 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.

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.

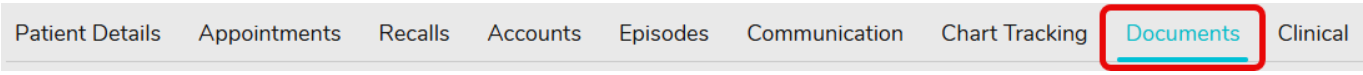


- **Add another referral**: FYDO allows you to have multiple referrals for a given patient. Use this button to add another referral
- **Edit referral**: this button allows you to make changes to any of the data fields of a given referral
- **Delete this referral**: this button will remove the referral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

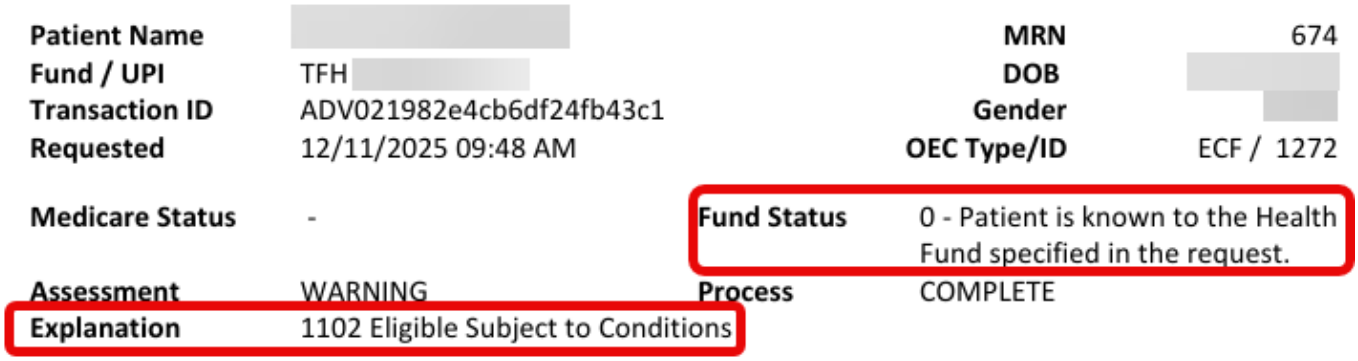
To find your **OEC**, first access the **Documents** from the patients record.



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	
IFC 2026-01-05	IFC	08/01/2026	05/01/2026	
OEC-39323	OEC	08/01/2026	05/01/2026	
OEC-39323	OEC	08/01/2026	05/01/2026	
OEC-39323	OEC	08/01/2026	05/01/2026	
OEC-61109	OEC	08/01/2026	05/01/2026	
IFC 2025-12-22	IFC	08/01/2026	22/12/2025	

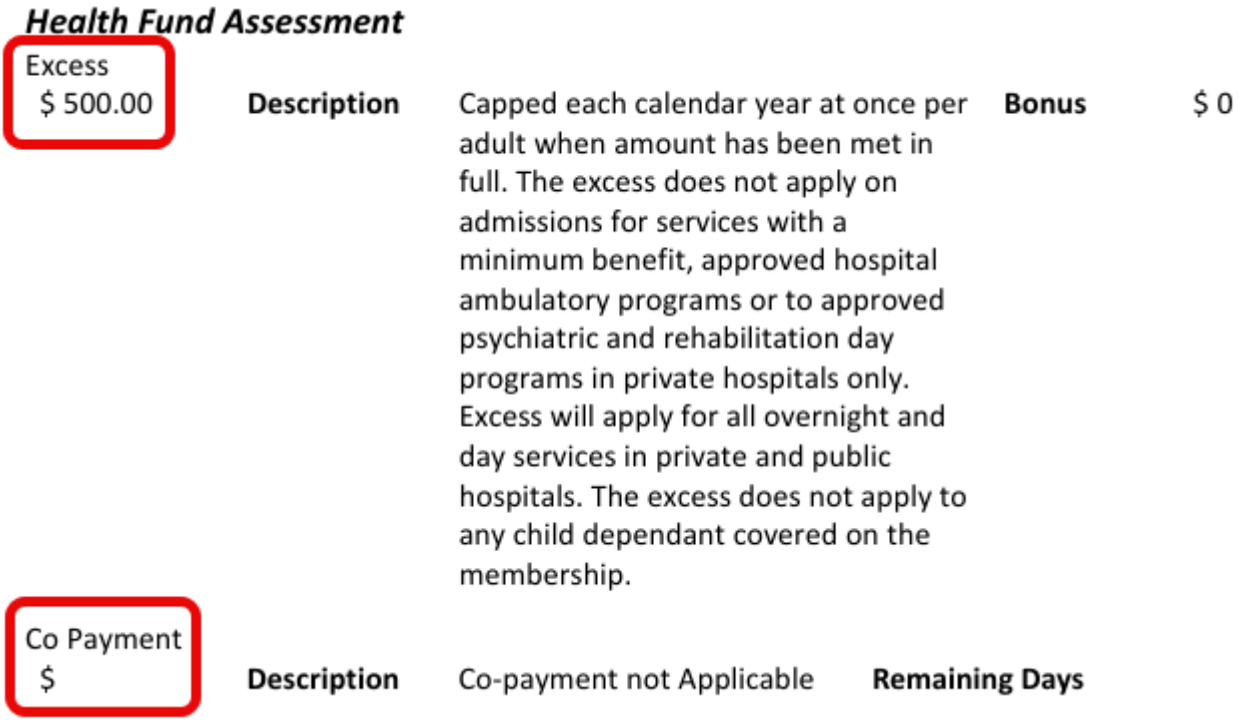
The first part of your **OEC** contains some patient information, as well as the **Fund** status on the check. It will also show the **Explanation**, on our **OEC** below we can see that the patient is eligible, but subject to conditions. The conditions will need to be confirmed with the fund:



Patient Name		**MRN**	674
Fund / UPI	TFH	**DOB**	
Transaction ID	ADV021982e4cb6df24fb43c1	**Gender**	
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.*

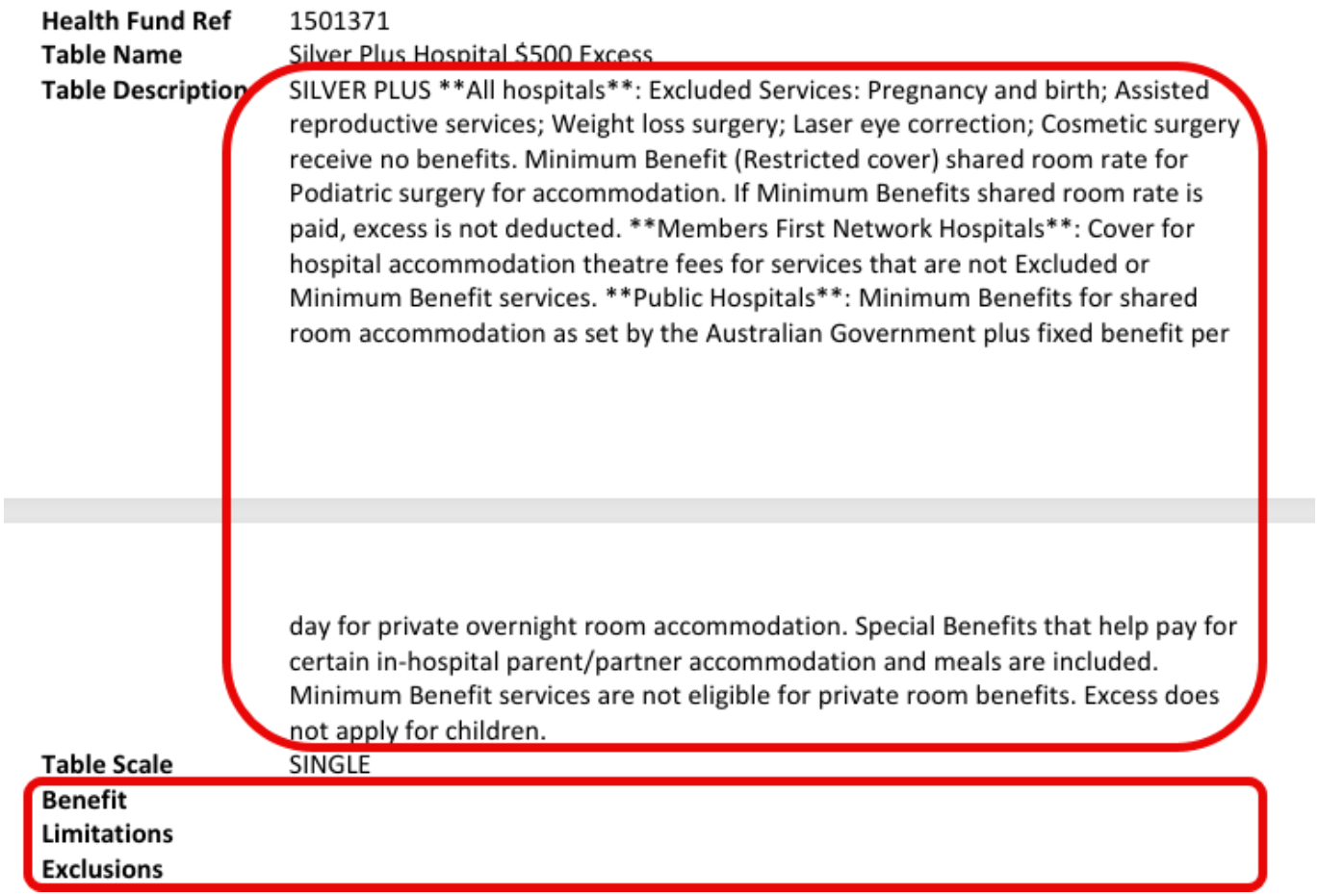


Health Fund Assessment

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**	

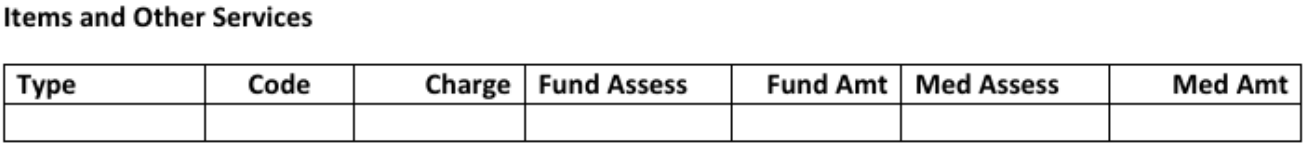
Just below the excess and co payment information, you will find the final details of the **OEC**. The fund will detail the members cover and the description will mention services that are excluded. There is also space for **Benefit Limitations** and **Exclusions**. If your **OEC** shows the patient as 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.

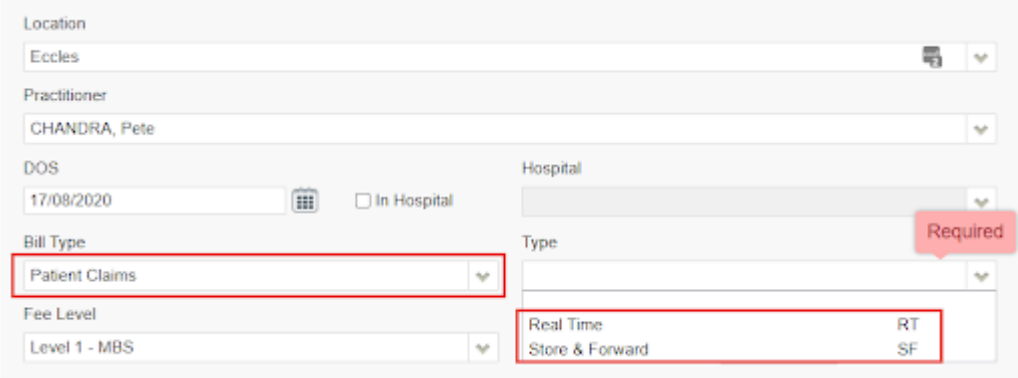
Need to learn more about Patient Claims first? Click here for more.

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

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



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

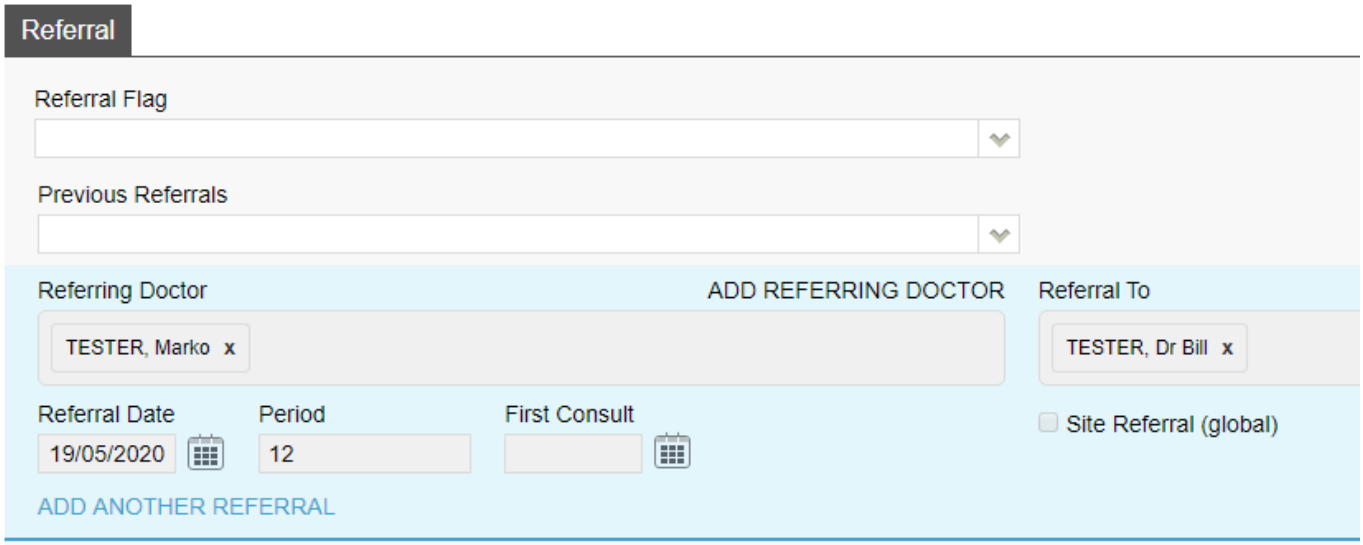
- Should you need to delete an invoice after creating it, you have until the close of business that day to delete it, via the software. This is called '**Same Day Delete**'
- However, if you realise you need to delete an invoice the next day or later, you will now need to contact Medicare and ask them 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).

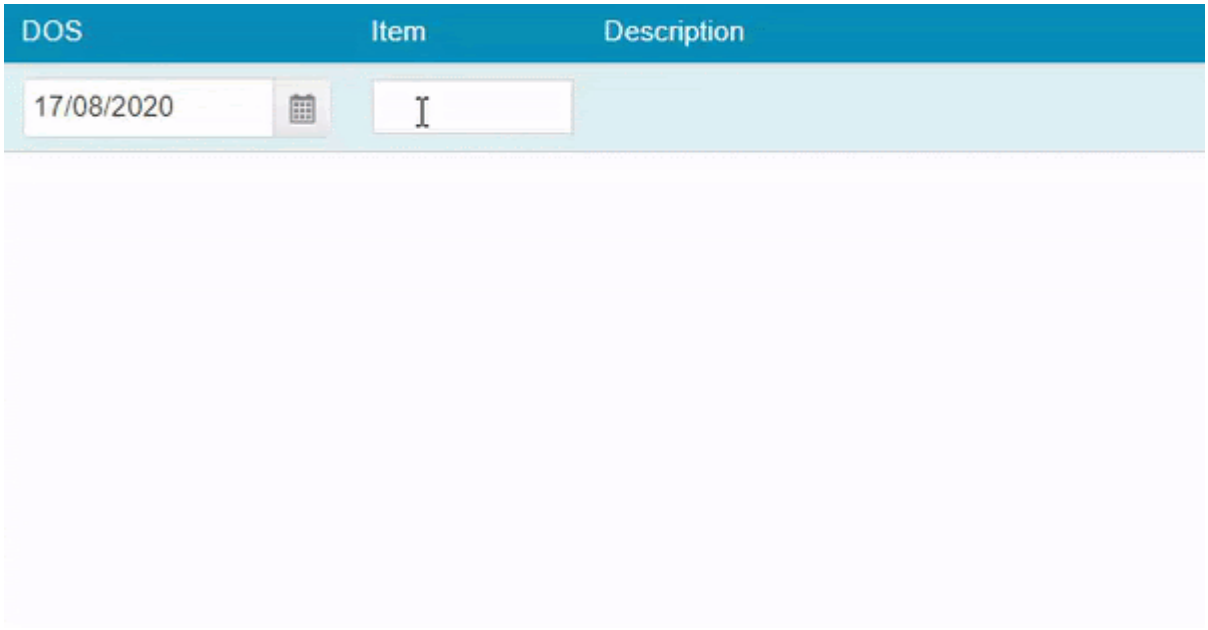


Once you are done with the above segments, click on the green **Add Items** button in the bottom left corner of your screen.

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!**



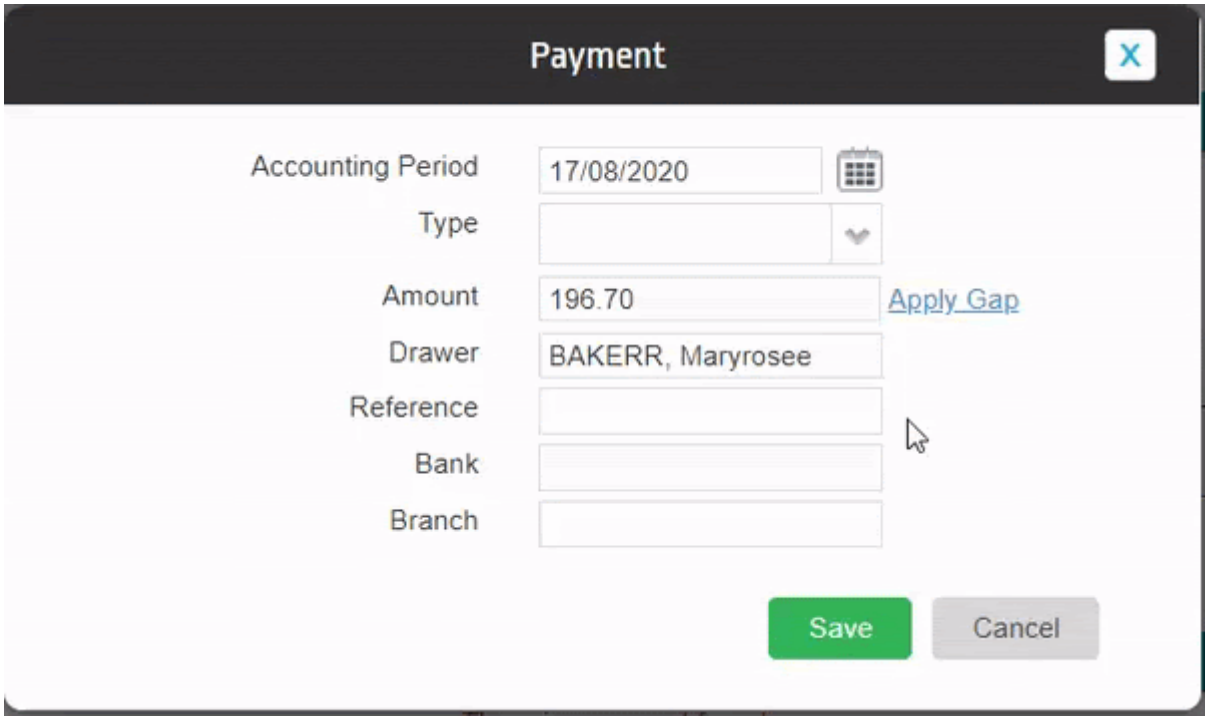
Notice that for **Patient Claims**, the **Date of Service (DOS)** can be changed in an invoice.

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:

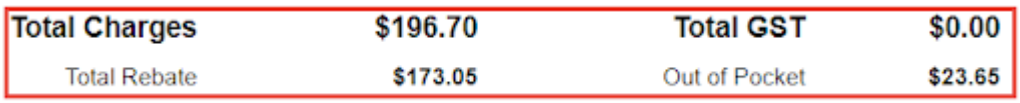


Once you have entered all your items and payments as desired, click on the **Review Charges** button to proceed to the final page of billing.

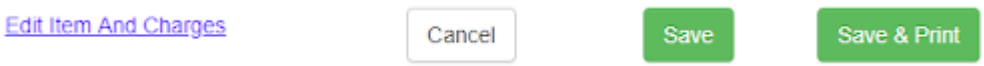
Clinic Review Charges

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:



Lets go over the options on this screen:



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.

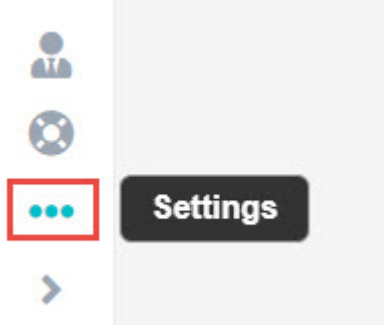
Health Fund Fees (Clinic)

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				
1	MBS 100%	0.00	01/11/2019				
2	Workers Comp	0.00	01/11/2019				
3	hcf no gap	0.00	01/07/2020	HCF		No Gap	☑
4	hcf with gap	0.00	01/07/2020	HCF		Gap / Known Gap	☑
5	ahsa nsw	0.00	01/07/2020	AHS	NSW		☑
6	medibank	0.00	01/07/2020	MPL			☑

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.

Disclaimer*: ACSS 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.*

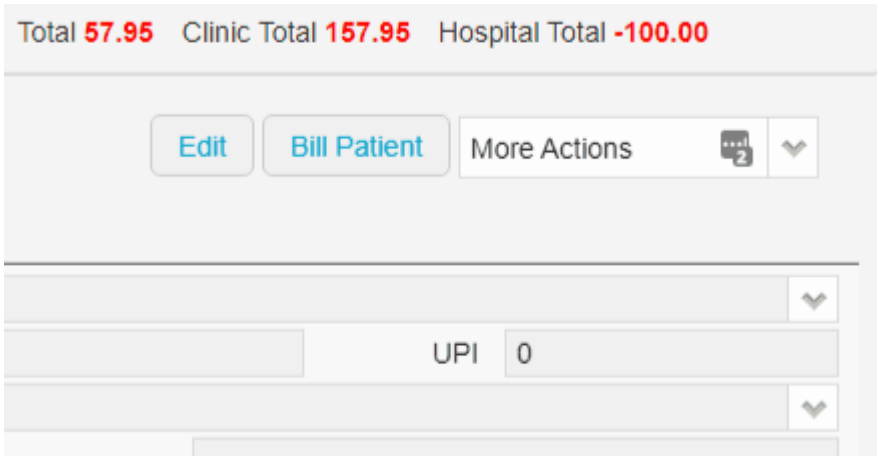
You can find the fees that Fydo will import ***here.***

How to run a Clinic OEC – Online Eligibility Check

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

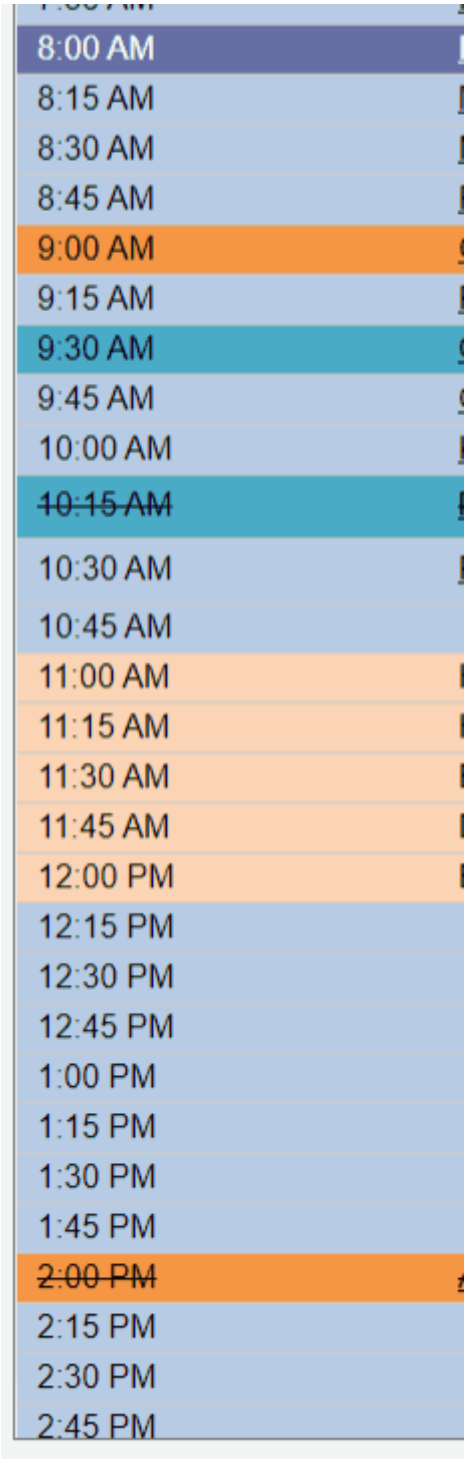
Patient Record

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**.



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

OEC Request

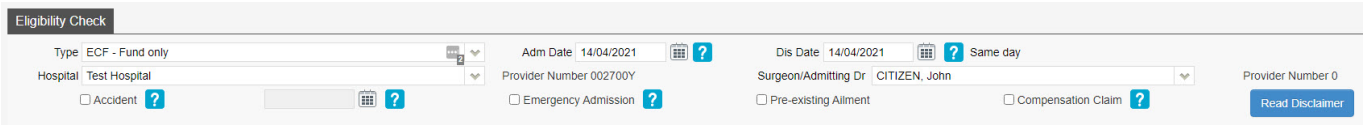
The next step is the fill out the required fields in the **OEC request.**

Patient Details

The patient details will be automatically filled in by information taken from the patients record such as **Name, Fund, DOB, Membership Number, Medicare Number** and **Gender.**

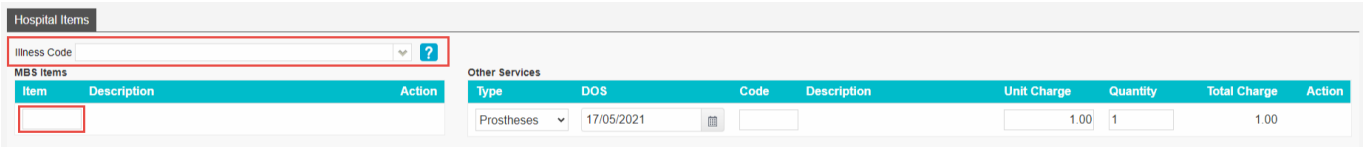
Eligibility Check

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.***

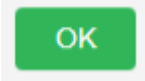


Items

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.



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

Medicare and Fund Contacts – Dealing with Rejections

Medicare & DVA

Organisation	Phone/ Email
Medicare	P: 1800 700 199F: 02 9895 3190
MBS Interpretation	P: 13 21 50E: askMBS@health.gov.au
DVA	P: 1300 550 017

Health Funds

Fund name	Contact for clinics	Contact for hospitals
ACA Health *ECLIPSE code: ACA* *HCP code: ACA*	P: 1300 368 390 acahealthit@acahealth.com.au	P: 1300 368 390 acahealthit@acahealth.com.au
Alliance (AHSA)	P: 03 9813 4088 access@ahsa.com.au	
AHM *ECLIPSE code: AHM* *HCP code: AHM*	P: 1300 524 456 Eclipse@medibank.com.au	P: 1300 560 680 Eclipse@medibank.com.au *AHM and Medibank have the same support team*
Australian Unity *ECLIPSE code: AUH* *HCP code: AUF*	P: 1800 035 360	P: 1800 035 360 dgilder@australianunity.com.au
BUPA*E* *CLIPSE code: BUP* *HCP code: BUP*	P: 134 135F: 1300 130 623 *for sending claims manually*dr.billing@bupa.com.au ***Only*** *for sending claims with Problems / Rejections* gapscheme@bupa.com.au ***Only*** *for if you are unable to* ***fax***	P: 134 135 gordon.barrett@bupa.com.au
CBHS Corporate Health & CBHS Health Fund *ECLIPSE code: CBC & CBH* *HCP code: CBC & CBH*	P: 1300 654 123 providers@cbhs.com.au	P: 1300 654 123 access@cbhs.com.au Alternatively julie.mckinnon@cbhs.com.au
Hunter Health Insurance (Formally known as 'Cessnock' or 'CDHBF Health') *ECLIPSE code: CDH* *HCP code: CDH*	P: 02 4990 1385 enquiries@hunterhi.com.au	P: 02 4990 1385 CDH.BenefitsFund@Hunterhi.com.au
CUA Health Limited *ECLIPSE code: CHF* *HCP code: CPS*	P: 1300 499 260 cuahealth@cuahealth.com.au	P: 1300 499 260 cuahealth@cuahealth.com.au *Alternatively* karen.coventry@cua.com.au

Defence Health *ECLIPSE code: DHF* *HCP code: AHB*	P: 1800 656 329	P: 1800 656 329 providerrelations@defencehealth.com.au
Doctors Health Fund *ECLIPSE code: AMA* *HCP code: AMA*	P: 1800 226 586	P: 1800 226 586 lesley.rutter@doctorshealthfund.com.au
Emergency Services Health (also managed by Police Health) *ECLIPSE code: ESH* *HCP code: SPE*	P: 1300 703 703 F: 1300 151 152	P: 1300 703 703 providerenquiries@eshealth.com.au
GMHBA *ECLIPSE code: GMH* *HCP code: GMH*	P: 1300 446 422 F: (03) 5222 7478	P: 1300 446 422 Jamie-LeeGardham@gmhba.com.au joannesheldon@gmhba.com.au
GU Health (FAI) *ECLIPSE code: FAI* *HCP code: FAI*	P: 1800 249 966 corporate@guhealth.com.au	providers@honeysucklehealth.com.au
HBF *ECLIPSE code: HBF* *HCP code: HBF*	P: 1300 810 475 expresspayqueries@hbf.com.au	P: 1300 810 475 lorraine.hort@hbf.com.au
HIF(Health Insurance Fund of Australia Limited) *ECLIPSE code: HIF* *HCP code: HIF*	P: 1300 134 060 claims@hif.com.au	P: 1300 134 060 michelle.peacock@hif.com.au
HCF *ECLIPSE code: HCF* *HCP code: HCF*	P: 1800 670 302 medicoverenquiry@hcf.com.au	P: 1800 670 302 MFarlow@hcf.com.au (Maria) Alternatively dfernandez@hcf.com.au (David)
Health Care Insurance *ECLIPSE code: HCI* *HCP code: HCI*	P: 1800 804 950	P: 1800 804 950 jamie.gillam@hciltd.com.au
Health Partners *ECLIPSE code: SPS* *HCP code: SPS*	P: 1300 113 113	P: 1300 113 113 hospitalclaims@healthpartners.com.au davids@healthpartners.com.au
Health.com.au *ECLIPSE code: HEA* *HCP code: HEA*	P: 1300 199 802	P: 1300 199 802 hospitalteam@health.com.au *Alternatively* Catherine.Ngo@health.com.au Gemma.Oliver@health.com.au
Latrobe *ECLIPSE code: LHS* *HCP code: LHS*	P: 1300 362 144 E: info@lhs.com.au	P: 1300 362 144 tan@lhs.com.au
Medibank *ECLIPSE code: MPL* *HCP code: MPL*	P: 1300 130 460	P: 1300 130 460 medibankhospital.network@medibank.com.au
Mildura *ECLIPSE code: MDH* *HCP code: MDH*	P: 03 5023 0269 providers@mildurahealthfund.com.au	P: 03 5023 0269 eclipse@mildurahealthfund.com.au

MO Health *ECLIPSE code: MYO* *HCP code: MYO*	P: 1800 333 004	P: 1800 333 004 Vaibhav.Makin@aia.com
Navy Health *ECLIPSE code: NHB* *HCP code: NHB*	P: 1300 217 736 query@navyhealth.com.au	query@navyhealth.com.au
NIB *ECLIPSE code: NIB* *HCP code: NIB*	P: 1300 853 530 medigap@nib.com.au Overseas Claims: internationalclaims@nib.com.au	P: 1300 853 530 hospitaleclipse@nib.com.au provrel@nib.com.au
Nurse and Midwives *ECLIPSE code: NMW* *HCP code: NMW*	P: 1300 344 000 submit.claim@nmhealth.com.au	P: 1300 344 000 EclipseClaims@nmhealth.com.au Alternatively George.Drakakis@nmhealth.com.au dianne.roe@teachershealth.com.au
OneMediFund *ECLIPSE code: OMF* *HCP code: OMF*	P: 1800 148 626 F: 1300 673 406	P: 1800 148 626 info@onemedifund.com.au
Peoplecare Health Insurance *ECLIPSE code: LHM* *HCP code: LHM*	P: 1800 808 690	P: 1800 808 690 info@peoplecare.com.au
Phoenix Health *ECLIPSE code: PHF* *HCP code: PWA*	P: 1800 028 817	P: 1800 028 817 enquiries@phoenixhealthfund.com.au info@peoplecare.com.au
Police Health (also managed by Emergency Services Health) *ECLIPSE code: POL* *HCP code: SPE*	P: 1800 603 603 F: 1800 008 554	P: 1800 603 603 providerenquiries@policehealth.com.au
Queensland Country *ECLIPSE code: QCH* *HCP code: QCH*	P: 1800 813 415	P: 1800 813 415 rharding@qccu.com.au
TUH(Queensland Teachers) *ECLIPSE code: QTU* *HCP code: QTU*	P: 1300 360 701	P: 1300 360 701 alice.caldwell@tuh.com.au
Reserve Bank health *ECLIPSE code: RBH* *HCP code: RBH*	P: 1800 027 299 F: 1300 309 704	P: 1800 027 299 info@myrbhs.com.au
RT Health *ECLIPSE code: RTH* *HCP code: RTE*	P: 1300 886 123 (option 5) access@rthealthfund.com.au	P: 1300 886 123 hospitals@rthealthfund.com.au
St Lukes *ECLIPSE code: SLM* *HCP code: SLM*	P: 1300 651 988	P: 1300 651 988 general@stlukes.com.au
Teachers Federation *ECLIPSE code: TFH* *HCP code: NTF*	P: 1300 728 188	P: 1300 728 188 elizabeth.cashman@teachershealth.com.au Alternatively, try: EclipseClaims@teachershealth.com.au George.Drakakis@nmhealth.com.au dianne.roe@teachershealth.com.au

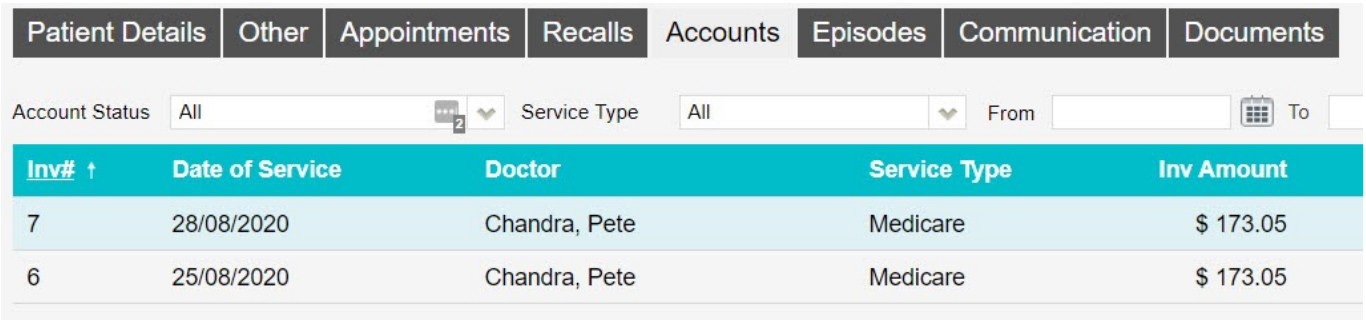
Transport Health *ECLIPSE code: TFS* *HCP code: TFS*	P: 1300 806 808	P: 1300 806 808 hospitals@transporthealth.com.au
Westfund *ECLIPSE code: WFD* *HCP code: WFD*	P: 1300 937 838 medicalbenefits@westfund.com.au	P: 1300 937 838 sharpg@westfund.com.au

---

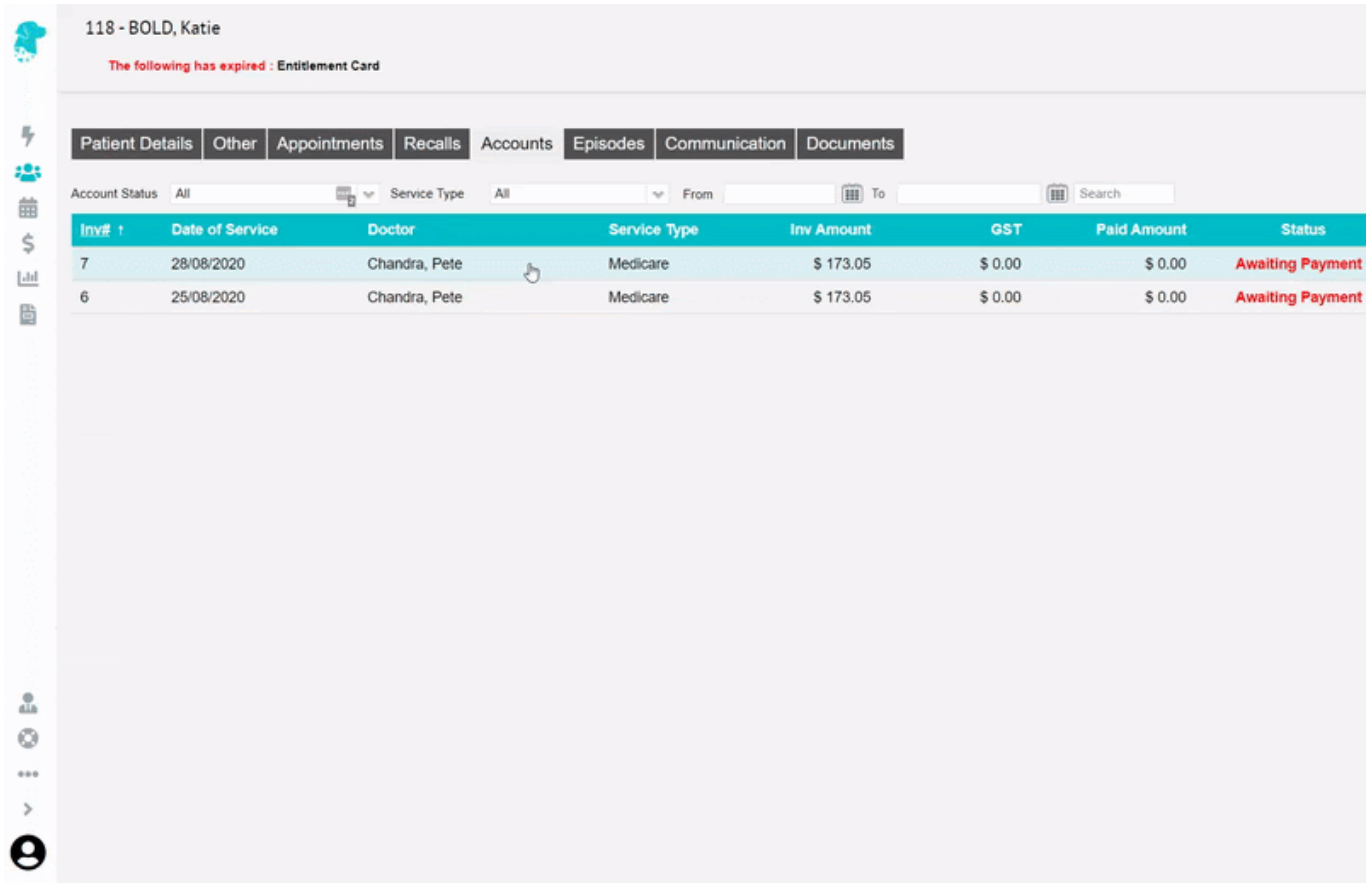
Printing Clinic Invoices Through Patient Records

Start off by opening the patient in question's record and hit the **Accounts** button.

This button reveals a patient's billing/ treatment history where **each line is an invoice**:



So from here, simply right click on the desired invoice to be printed and select **Print Invoice**. This will produce a **PDF** file of the invoice, which you may print or store/ send electronically.



If selecting **Print Invoice** presents you with the below message, this means you do not have an **invoice template** for the *type of invoice* you are attempting to print,

So, [click here to view our guide on how to **upload an invoice template**.]