Importing Radiology Claims – ECLIPSE

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

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

Minimum Data Set

Everything is mandatory unless stated otherwise.

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

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

- Charge for Item *(optional)*
- Service Text *(conditional)*
- Restrictive Override Code *(conditional)*
- Duplicate Service Override Indicator *(conditional)*
- Duplicate Service Override Text *(conditional)*
- Paid Amount *(conditional)*

Notes

Patient Fields

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

Token name is: ExternalPatientId

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

Tokens available:

- PatientFirstName
- PatientMiddleName
- PatientFamilyName

Patient Gender – patient gender.

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

Token name is: PatientGender

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

Tokens available:

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

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

Token name is: FundBrandID

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

Token name is: PatientFundMembershipNum & PatientFundUPI

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

Token name is: FundPayeeID

Invoice Fields

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

Token name is: ExtServicingDoctor

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

Token name is: ExternalInvoice

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

- N – Inpatient/ In-hospital

Token name is: TypeOfService

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

- S – Specialist

Token name is: ServiceTypeCde

Location Specific Practice Number – code provided to each practice.

Token name = LSPNum

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

Token name is: FacilityId

Benefit Assignment Authorised – Indicates that the patient has authorised the assignment of their rights of benefit to a provider. Always indicate authorised.
Required when 'Type of Service' is M or V, not required when Service Type = P. If set to N, the claim will not import.

- Y – Authorised

Token name = BenefitAssignmentAuthorised

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

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

Token name = NumberItems

Referral Fields

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

Tokens available:

- *RefDrFirstName*
- *RefDrLastName*
- *RefDrTitle*
- *RefDrAddress*
- *RefDrSuburb*
- *RefDrState*
- *RefDrPostcode*

- *RefDrPhone*
- *RefDrfax*
- *RefDrEmail*

Referring Provider Number – provider number of the referring doctor.

Token name is: ReferringProviderNum

Referral Date – Date of the referral.

Format dd/mm/yyyy

Token name is: ReferralIssueDate

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

- 3
- 12
- 99 (Indefinite)

Token name is: ReferralPeriod

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

D – Diagnostic

Token name is: RequestTypeCde

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

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

Token name: ReferralOverrideTypeCde

IMC Specific Fields

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

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

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

Token name is: FinancialInterestDisclosureInd

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

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

Token name is: AccidentInd

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

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

Token name is: CompensationClaimInd

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

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

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

Token name is: IFCIssueCde

Fields related to the Item

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

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

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

Token name: RestrictiveOverrideInd

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

- Y – Not Duplicate
- N – Duplicate

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

Token name: DuplicateServiceOverrideInd

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

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

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

Token name is: TimeOfService

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

Token name = ServiceText

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

Token name = PaidAmount

Other tokens that might be required

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

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

Tokens available:

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

- *ClaimantAddressLine1*
- *ClaimantAddressLocality*
- *ClaimantAddressPostcode*

Returned Files that can be imported back into your system

This is an optional step, and is useful provided your main system can import files.
Read more at Claims Import – Returned Files – FYDO Wiki

Sample Files

Importing Pathology Claims – ECLIPSE

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

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

Minimum Data Set

Everything is mandatory unless stated otherwise.

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

- **Claim Data**
  - Type of Service

    - Service Type Code
    - External Invoice ID (optional)
    - External Servicing Provider ID
    - Referring Dr Details (optional)
    - Referring Dr Provider Number
    - Referral Date
    - Specimen Collection Point (SCP)
    - Facility Provider Number
    - Benefit Assignment Authorised
    - Financial Interest Disclosure Indicator
    - Accident Indicator
    - Account Paid Indicator
    - IFC Issue Code
    - Total Invoice/Claim Amount (optional)
    - Number of Items
    - Time of Service (conditional)
    - Item
        - Date of Service
        - Rule 3 Exempt Indicator
        - S4B3 Exempt Indicator
        - Accession Date and Time (conditional)
        - Collection Date and Time (conditional)
        - Charge for Item (optional)
        - Service Text (conditional)

Notes

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

Tokens available:

- PatientFirstName
- PatientSecondInitial
- PatientFamilyName

Patient Gender – patient gender.

- F = Female

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

Token name is: PatientGender

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

Tokens available:

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

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

Token name is: FundBrandID

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

Token name is: PatientFundMembershipNum & PatientFundUPI

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

Token name is: FundPayeeID

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

Token name is: ExternalPatientId

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

Token name is: ExtServicingDoctor

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

Token name is: ExternalInvoice

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

- N – Inpatient/ In-hospital..

Token name is: TypeOfService

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

- P – Pathology

Token name is: ServiceTypeCde

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

Tokens available:

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

Referring Provider Number – provider number of the referring doctor.

Token name is: ReferringProviderNum

Referral Date – Date of the referral.

Format dd/mm/yyyy

Token name is: ReferralIssueDate

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

Token name is: ReferralPeriod

Specimen Collection Point – code provided to each pathology lab.

Token name = SCPId

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

Token name is: FacilityId

Benefit Assignment Authorised – Indicates that the patient has authorised the assignment of their rights of benefit to a provider. Always indicate authorised.
Required when 'Type of Service' is M or V, not required when Service Type = P. If set to N, the claim will not import.

- Y – Authorised

Token name = BenefitAssignmentAuthorised

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

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

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

Token name is: FinancialInterestDisclosureInd

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

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

Token name is: AccidentInd

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

Token name = AccountPaidInd

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

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

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

Token name is: IFCIssueCde

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

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

Token name = NumberItems

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

Token name = Rule3ExemptInd

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

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

- Y – Exempt
- N – Not Exempt

Token name = S4B3ExemptInd

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

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

Format DDMMYYYYHHMM e.g. 300620161330

Token name = CollectionDateTime

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

Format DDMMYYYYHHMM e.g. 300620161330

Token name = AccessionDateTime

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

Token name is: TimeOfService

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

Token name = ServiceText

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

Other tokens that might be required

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

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

Tokens available:

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

Returned Files that can be imported back into your system

This is an optional step and is useful provided your main system can import files.
Read more at Claims Import – Returned Files – FYDO Wiki

Sample Files

Importing Specialist Claims – Eclipse

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

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

Minimum Data Set

Everything is mandatory unless stated otherwise.

Patient Information

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

Claim Data

- External Invoice ID (optional)
- External Servicing Provider ID
- Type of Service
- Service Type Code
- Financial Interest Disclosure Indicator
- Accident Indicator
- IFC Issue Code
- Benefit Assignment Authorised
- Facility Provider Number
- Referring Dr Details (optional)
- Referring Dr Provider Number
- Referral Date
- Referral Period Type
- Referral Period (conditional)
- Invoice/Claim Amount [Total] (conditional)
- Number of Items

- Item
    - Date of Service
    - Charge [for each item] (conditional)
    - Service Text (conditional)
    - Time of Service (conditional)
    - Number of Patients Seen (conditional)
    - Self Deemed
    - Multiple Procedure Override
    - Duplicate Service Override

Notes

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

Token name is: ExternalPatientID

Gender – patient gender.

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

Token name is: PatientGender

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

Tokens available:

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

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

Token name is: PatientFundUPI

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

Token name is: FundBrandID

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

Token name is: FundPayeeID

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

Token name is: ExternalInvoice

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

Token name is: ExtServicingDoctor

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

- N – Inpatient/ In-hospital

Token name is: TypeOfService

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

- S – Specialist

Token name is: ServiceTypeCde

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

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

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

Token name is: FinancialInterestDisclosureInd

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

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

Token name is: AccidentInd

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

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

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

Token name is: IFCIssueCde

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

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

Token name is: BenefitAssignmentAuthorised

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

Token name is: FacilityId

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

Tokens available:

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

- *RefDrfax*
- *RefDrEmail*

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

Token name is: ReferringProviderNum

Referral Date – format is dd/mm/yyyy

Token name is: ReferralIssueDate

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

Token name is: ReferralPeriod

Invoice / Claim Amount [Total] – Conditional. This is the total amount of the invoice / claim for all items within the invoice. If you cannot pass this information, then we can setup fees in Fydo.

Token name is: BClmAmt

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

Token name is: NumberItems

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

Token name is: ChargeAmount

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

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

Token name is: SelfDeemedCde

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

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

- Y – Not Multiple

- N – Multiple

Token name is: MultipleProcedureOverrideInd

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

- Y – Not Duplicate
- N – Duplicate

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

Token name is: DuplicateServiceOverrideInd

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

Token name is: NoOfPatientsSeen

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

Token name is: TimeOfService

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

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

Token name is: ServiceText

Returned Files that can be imported back into your system

This is an optional step and is useful provided your main system can import files.
Read more at Claims Import – Returned Files – FYDO Wiki

Sample Files

Importing Specialist Claims – Medicare / DVA / Patient Claims

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

Minimum Data Set

Everything is mandatory unless stated otherwise.

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

- **Claim Data**
  - Type of Service
  - Service Type Code
  - External Invoice ID *(optional)*
  - External Servicing Provider ID
  - Referring Dr Title *(optional)*
  - Referring Dr First name *(optional)*
  - Referring Dr Last name *(optional)*
  - Referring Dr Provider Number
  - Referral Date
  - Referral Period
  - Veterans Service Type *(conditional)*
  - Treatment Location *(conditional)*
  - Benefit Assignment Authorised
  - Total Invoice/Claim Amount *(optional)*
  - Number of Items
  - Item/s
    - Date of Service
    - Hospital Indicator *(conditional)*
    - Number of Patients Seen *(conditional)*

- Self Deemed
- Multiple Procedure Override
- Duplicate Service Override
- Charge for Item *(optional)*
- Service Text *(conditional)*

Notes

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

Token name is: ExternalPatientId

Gender – patient gender.

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

Token name is: PatientGender

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

Tokens available:

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

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

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

Token name is: TypeOfService

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

- S – Specialist

Token name is: ServiceTypeCde

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

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

Token name is: VaaServiceTypeCde

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

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

Token name is: TreatmentLocationCde

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

Token name is: ExtServicingDoctor

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

Token name is: ExternalInvoice

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

Tokens available:

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

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

Token name is: ReferringProviderNum

Referral Date – format is dd/mm/yyyy

Token name is: ReferralIssueDate

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

Token name is: ReferralPeriod

Benefit Assignment Authorised – Indicates that the patient has authorised the assignment of their rights of benefit to a provider. Always indicate authorised.
Required when 'Type of Service' is M or V, not required when Service Type = P. If set to N, the claim will not import.

- Y – Authorised

Token name = BenefitAssignmentAuthorised

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

Token name = NumberItems

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

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

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

Token name: SelfDeemedCde

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

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

- Y – Not Multiple
- N – Multiple

Token name: MultipleProcedureOverrideInd

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

- Y – Not Duplicate
- N – Duplicate

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

Token name: DuplicateServiceOverrideInd

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

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

Token name is: NoOfPatientsSeen

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

conditional.

- Y – In hospital
- N – Not in hospital

Token name: HospitalInd

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

Token name is: FacilityId

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

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

Token name = ServiceText

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

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

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

Tokens available:

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

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

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

Token name = AccountPaidInd

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

- Y – Authorised
- N – Unauthorised

Token name = ClaimSubmissionAuthorised

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

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

Returned Files that can be imported back into your system

This is an optional step and is useful provided your main system can import files.
Read more at Claims Import – Returned Files – FYDO Wiki

Sample Files

Importing Radiology Claims

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

Minimum Data Set

Everything is mandatory unless stated otherwise.

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

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

Notes

Patient Fields

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

Token name is: ExternalPatientId

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

Tokens available:

- PatientFirstName

- PatientSecondInitial
- PatientFamilyName

Patient Gender – patient gender.

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

Token name is: PatientGender

Patient Medicare / Veterans card – this is conditional.

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

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

Tokens available:

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

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

Tokens available:

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

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

Invoice Fields

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

Token name is: ExtServicingDoctor

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

Token name is: ExternalInvoice

LSPN – Location Specific Practice Number.
Must be set if Equipment Id is set.

Token name: LSPNum

Benefit Assignment Authorised – Indicates that the patient has authorised the assignment of their rights of benefit to a provider. Always indicate authorised.
Required when 'Type of Service' is M or V, not required when Service Type = P. If set to N, the claim will not import.

- Y – Authorised

Token name = BenefitAssignmentAuthorised

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

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

Token name is: TreatmentLocationCde

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

Token name = 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

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*
- *ClaimantAddressLocality*
- *ClaimantAddressPostcode*

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

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

Token name = AccountPaidInd

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

- Y – Authorised
- N – Unauthorised

Token name = ClaimSubmissionAuthorised

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

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

Returned Files that can be imported back into your system

This is an optional step and is useful provided your main system can import files.
Read more at Claims Import – Returned Files – FYDO Wiki

Sample Files

Importing Pathology Claims – Medicare / DVA / Patient Claims

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

Minimum Data Set

Everything is mandatory unless stated otherwise.

- **Patient Info**
  - External Patient ID
  - First Name

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

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

Notes

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

Token name is: ExternalPatientId

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

Tokens available:

- PatientFirstName
- PatientSecondInitial
- PatientFamilyName

Patient Gender – patient gender.

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

Token name is: PatientGender

Patient Medicare / Veterans card – this is conditional.

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

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

Tokens available:

- PatientMedicareCardNum
- PatientReferenceNum
- VeteranFileNum

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

Tokens available:

- *PatientAddressLine*

- *PatientAddressLocality*
- *PatientPostcode*

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

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

Token name is: TypeOfService

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

- P – Pathology

Token name is: ServiceTypeCde

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

Token name is: ExtServicingDoctor

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

Token name is: ExternalInvoice

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

Tokens available:

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

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

Token name is: ReferringProviderNum

Referral Date – Date of the referral.

Format dd/mm/yyyy

Token name is: ReferralIssueDate

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

Token name: ReferralPeriod

Referral Request Type – Indicates the type of request.

- P – Pathology
- D – Diagnostic Imaging

Token name: RequestTypeCde

Specimen Collection Point – code provided to each pathology lab.

Token name = SCPId

Benefit Assignment Authorised – Indicates that the patient has authorised the assignment of their rights of benefit to a provider. Always indicate authorised.
Required when 'Type of Service' is M or V, not required when Service Type = P. If set to N, the claim will import but the claim will be printed, basically it reverts back to manual not electronic submission.

- Y – Authorised
- N – Not Authorised

Token name = BenefitAssignmentAuthorised

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

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

Token name is: TreatmentLocationCde

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

Token name = 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

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

Token name = NumberItems

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

- Y – In hospital
- N – Not in hospital

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

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

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

Token name: HospitalInd

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

Token name = Rule3ExemptInd

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

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

- Y – Exempt
- N – Not Exempt

Token name = S4B3ExemptInd

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

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

Format DDMMYYYYHHMM e.g. 300620161330

Must be set if S4B3 Exemption Indicator is set to Y.
Must be present if Accession Date & Time is present.

Token name = CollectionDateTime

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

Format DDMMYYYYHHMM e.g. 300620161330

Must be

Token name = AccessionDateTime

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

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

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

Token name is: TimeOfService

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

Token name = ServiceText

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

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

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

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

Tokens available:

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

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

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

Token name = AccountPaidInd

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

- Y – Authorised
- N – Unauthorised

Token name = ClaimSubmissionAuthorised

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

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

Returned Files that can be imported back into your system

This is an optional step, and is useful provided your main system can import files.
Read more at Claims Import – Returned Files – FYDO Wiki

Sample Files

Importing 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)
  - Invoice/Claim Amount (optional)
  - Benefit Assignment Authorised (mandatory when using XML format, otherwise not required)
  - Date of Service
  - Item
    - No Of Patients Seen (conditional)
    - Distance in KMs (conditional)
    - Charge (optional)
    - Multiple Procedure Override
    - Duplicate Service Override

Notes

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

Token name is: ExternalPatientId

Gender – patient gender.

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

Token name is: PatientGender

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*

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 provider the actual provider number, you can place your own unique code, and we will map that code to your actual provider number.

Token name is: ExtServicingDoctor

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

Token name is: ExternalInvoice

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 = 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

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

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

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)*
  - Invoice/Claim Amount *(optional)*
  - 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)
  - Item
    - Date Of Service
    - 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*

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 provider the actual provider number, you can place your own unique code, and we will map that code to your actual provider number.

Token name is: ExtServicingDoctor

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

Token name is: ExternalInvoice

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

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*
- *ClaimantAddressLocality*
- *ClaimantAddressPostcode*

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

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

Token name = AccountPaidInd

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

- Y – Authorised
- N – Unauthorised

Token name = ClaimSubmissionAuthorised

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

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

Returned Files that can be imported back into your system

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

Read more at Claims Import – Returned Files – FYDO Wiki

Sample File

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)
- Invoice/Claim Total Amount (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 provider the actual provider number, you can place your own unique code, and we will map that code to your actual provider number.

Token name is: ExtServicingDoctor

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

Token name is: ExternalInvoice

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

Tokens available:

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

Referring provider Number – 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

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.

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

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.

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

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

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