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