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## Contents

**DEPARTMENT OF EMPLOYMENT AND LABOUR**

**GENERAL NOTICE 151 OF 2021**

# CHIROPRACTOR GAZETTE 2021.

**COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993**
**(ACT 130 OF 1993 as amended by Act 61 of 1997)**

## NOTICE ON ANNUAL INCREASE IN MEDICAL TARIFFS PAYABLE UNDER SECTION 76 OF THE COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT AS AMENDED

**1.**

I, Thembelani Thulas Nxesi, Minister of Employment & Labour, hereby give notice that, after consultation with the Compensation Board and acting under powers vested in me by section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.130 of 1993), prescribe the scale of "Fees for Medical Aid" payable under section 76, inclusive of the General Rule applicable thereto, appearing in the Schedule, with effect from 1 April 2021.

**2.**

Medical Tariffs increase for **2021** is **5.47%**

**3.**

The fees appearing in the Schedule are applicable in respect of services rendered on or after **1 April 2021** and Exclude **15% Vat.**

**MR TW NXESI, MP**
**MINISTER OF EMPLOYMENT AND LABOUR**
**DATE:** 2021/01/25

## GENERAL INFORMATION

### THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

**The employee is permitted to freely choose his own service provider e.g. doctor, pharmacy, physiotherapist, hospital, etc.** and no interference with this privilege is permitted, as long as it is exercised reasonably and without prejudice to the employee or to the Compensation Fund. The only exception to this rule is in case where an employer, with the approval of the Compensation Fund, provides comprehensive medical aid facilities to his employees, i.e. including hospital, nursing and other services — section 78 of the Compensation for Occupational Injuries and Diseases Act refers.

In terms of section 42 of the Compensation for Occupational Injuries and Diseases Act, the Compensation Fund may refer an injured employee to a specialist medical practitioner designated by the Director General for a medical examination and report. Special fees are payable when this service is requested.

In terms of section 76,3(b) of the Compensation for Occupational Injuries and Diseases Act, no amount in respect of medical expenses shall be recoverable from the employee.

In the event of a change of medical practitioner attending to a case, the first doctor in attendance will, except where the case is transferred to a specialist, be regarded as the principal. **To avoid disputes regarding the payment for services rendered, medical practitioners should refrain from treating an employee already under treatment by another doctor without consulting / informing the first doctor.** As a general rule, changes of doctor are not favoured by the Compensation Fund, unless sufficient reasons exist.

According to the National Health Act no 61 of 2003, Section 5, a health care provider may not refuse a person emergency medical treatment. Such a medical service provider should not request the Compensation Fund to authorise such treatment before the claim has been submitted to and accepted by the Compensation Fund. **Pre-authorisation of treatment is not possible and no medical expense will be approved if liability for the claim has not been accepted by the Compensation Fund.**

An employee seeks medical advice at his own risk. If an employee represented to a medical service provider that he is entitled to treatment in terms of the Compensation for Occupational Injuries and Diseases Act, and yet failed to inform the Compensation Commissioner or his employer of any possible grounds for a claim, the Compensation Fund cannot accept responsibility for medical expenses incurred. The Compensation Commissioner could also have reasons not to accept a claim lodged against the Compensation Fund. In such circumstances the employee would be in the same position as any other member of the public regarding payment of his medical expenses.

**Please note that from 1 January 2004 a certified copy of an employee's identity document will be required in order for a claim to be registered with the Compensation Fund.** If a copy of the identity document is not submitted the claim will not be registered but will be returned to the employer for attachment of a certified copy of the employee's identity document. Furthermore, all supporting documentation submitted to the Compensation Fund must reflect the identity number of the employee. If the identity number is not included such documents can not be processed but will be returned to the sender to add the ID number.

The tariff amounts published in the tariff guides to medical services rendered in terms of the Compensation for Occupational Injuries and Diseases Act do not include VAT. All accounts for services rendered will be assessed without VAT. Only if it is indicated that the service provider is registered as a VAT vendor and a VAT registration number is provided, will VAT be calculated and added to the payment, without being rounded off.

The only exception is the "per diem" tariffs for Private Hospitals that already include VAT.

Please note that there are VAT exempted codes in the private ambulance tariff structure.

## CLAIMS WITH THE COMPENSATION FUND ARE PROCESSED AS FOLLOWS

1. New claims are registered by the Employers and the Compensation Fund and the **employer views the claim number allocated online.** The allocation of a claim number by the Compensation Fund, does not constitute acceptance of liability for a claim, but means that the injury on duty has been reported to and registered by the Compensation Commissioner. Enquiries regarding claim numbers should be directed to the employer and not to the Compensation Fund. The employer will be in the position to provide the claim number for the employee as well as indicate whether the claim has been accepted by the Compensation Fund

2. If a claim is **accepted** as a COIDA claim, **reasonable medical expenses** will be paid by the Compensation Commissioner.

3. If a claim is **rejected (repudiated)**, medical expenses for services rendered will not be paid by the Compensation Commissioner. The employer and the employee will be informed of this decision and the injured employee will be liable for payment.

4. If **no decision** can be made regarding acceptance of a claim due to inadequate information, the outstanding information will be requested and upon receipt, the claim will again be adjudicated on. Depending on the outcome, the accounts from the service provider will be dealt with as set out in 2 and 3. Please note that there are claims on which a decision might never be taken due to lack of forthcoming information.

## BILLING PROCEDURE

1. All service providers should be registered on the Compensation Fund claims system in order to capture invoices and medical reports.

   1.1 Medical reports should always have a clear and detailed clinical description of injury and related ICD 10 Code.
   1.2 In a case where a surgical procedure is done, an operation report is required
   1.3 Only one medical report is required when multiple procedures are done on the same service date
   1.4 A medical report is required for every invoice submitted covering every date of service.
   1.5 Referrals to another medical service provider should be indicated on the medical report.
   1.6 Medical reports, referral letters and all necessary documents should be uploaded on the Compensation Fund claims system.

**NOTE: Service providers are required to keep original documents (i.e medical reports, invoices) and these should be made available to the Compensation Commissioner on request.**

2. Medical invoices should be switched to the Compensation Fund using the attached format. - Annexure D.

   2.1. Subsequent invoice must be electronically switched. It is important that all requirements for the submission of invoice, including supporting information, are submitted.
   2.2. Manual documents for medical refunds should be submitted to the nearest labour centre.
   2.3 Service providers may capture and submit medical invoices directly on the Compensation Fund system online application.

3. The status of invoices /claims can be viewed on the Compensation Fund claims system. If invoices are still outstanding after 60 days following submission, the service provider should complete an enquiry form, W.Cl 20, and submit it ONCE to the Provincial office/Labour Centre. All relevant details regarding Labour Centres are available on the website www.labour.gov.za .

4. If an invoice has been partially paid with no reason indicated on the remittance advice, an enquiry should be made with the nearest processing labour centre. The service provider should complete an enquiry form, W.Cl 20, and submit it ONCE to the Provincial office/Labour Centre. All relevant details regarding Labour Centres are available on the website www.labour.gov.za .

5. Details of the employee's medical aid and the practice number of the referring practitioner must not be included in the invoice.

- If a medical service provider claims an amount less than the published tariff amount for a code, the Compensation Fund will only pay the claimed amount and the short fall will not be paid.

6. Service providers should not generate the following:

   a. Multiple invoices for services rendered on the same date i.e. one invoice for medication and a second invoices for other services.
   b. Cumulative invoices – Submit a separate invoice for every month.

*** Examples of the new forms (W.Cl 4 / W.Cl 5 / W.Cl 5F) are available on the website www.labour.gov.za •**

## MINIMUM REQUIREMENTS FOR INVOICE RENDERED

**Minimum information** to be indicated on invoices submitted to the Compensation Fund

- Name of employee and ID number
- Name of employer and registration number if available
- Compensation Fund claim number
- DATE OF ACCIDENT (not only the service date)
- Service provider's **invoice number**
- The practice number (changes of address should be reported to BHF)
- VAT registration number (VAT will not be paid if a VAT registration number is not supplied on the account)
- Date of service (the actual service date must be indicated: the invoice date is not acceptable)
- Item codes according to the officially published tariff guides
- Amount claimed per item code and total of account
- It is important that all requirements for the submission of invoices are met, including supporting information, e.g:
    - All pharmacy or medication accounts must be accompanied by the original scripts
    - The referral letter from the treating practitioner must accompany the medical service providers' invoice.

**COMPENSATION FUND MEDICAL SERVICE PROVIDERS REGISTRATION REQUIREMENTS**

Medical service providers treating COIDA patients must comply with the following requirements before submitting medical invoices to the Compensation Fund:

- Medical Service Providers must register with the Compensation Fund as a Medical Service Provider.
- Render medical treatment to in terms of COIDA Section 76 (3) (b).
- Submit Proof of registration with the Board of Healthcare Funders of South Africa.
- Submit an applicable dispensing licence on registration as a medical service provider.
- Submit SARS Vat registration number document on registration.
- A certified copy of the MSP's Identity document not older than three months.
- Proof of address not older than three months.
- Submit medical invoices with gazetted COIDA medical tariffs, relevant ICD10 codes and additional medical tariffs specified by the Fund when submitting medical invoices.
- All medical invoices must be submitted with invoice numbers to prevent system rejections. Duplicate invoices should not be submitted.
- Provide medical reports and invoices within a specified time frame on request by the Compensation Fund in terms of Section 74 (1) and (2).
- Submit the following additional information on the Medical Service Provider letterhead, Cell phone number, Business contact number, Postal address, Email address. The Fund must be notified in writing of any changes in order to effect necessary changes on the systems.
- The name of the switching house that submit invoices on behalf of the medical service provider. The Fund must be notified in writing when changing from one switching house to another.

All medical service providers will be subjected to the Compensation Fund vetting processes.

The Compensation Fund will withhold payments if medical invoices do not comply with minimum submission and billing requirements as published in the Government Gazette.

## REQUIREMENTS FOR SWITCHING MEDICAL INVOICES WITH THE COMPENSATION FUND

The switching provider must comply with the following requirements:

1. Registration requirements as an employer with the Compensation Fund.
2. Host a secure FTP server to ensure encrypted connectivity with the Fund.
3. Submit and complete a successful test file before switching the invoices.
4 Validate medical service providers' registration with the Health Professional Council of South Africa.
5 Validate medical service providers' registration with the Board of Healthcare Funders of South Africa.
5. Ensure elimination of duplicate medical invoices before switching to the Fund.
6. Invoices submitted to the Compensation Fund must have Gazetted COIDA Tariffs that are published annually and comply with minimum requirements for submission of medical invoices and billing requirements.
7. File must be switched in a gazetted documented file format published annually with COIDA tariffs.
8. Single batch submitted must have a maximum of 100 medical invoices.
9. File name must include a sequential batch number in the file naming convention.
10. File names to include sequential number to determine order of processing.
11. Medical Service Providers will be subjected to Compensation Fund vetting processes.
12. Provide any information requested by the Fund.
13. The switching provider must sign a service level agreement with the Fund.
14. Third parties must submit power of attorney.
15. Only Pharmacies should claim from the Nappi codes file.

**Failure to comply with the above requirements will result in deregistration of the switching house.**

| MSP's PAID BY THE COMPENSATION FUND | |
|---|---|
| **Discipline Code :** | **Discipline Description :** |
| **4** | Chiropractors |
| **9** | Ambulance Services - advanced |
| **10** | Anesthetists |
| **11** | Ambulance Services - Intermediate |
| **12** | Dermatology |
| **13** | Ambulance Services - Basic |
| **14** | General Medical Practice |
| **15** | General Medical Practice |
| **16** | Obstetrics and Gynecology (work related injuries) |
| **17** | Pulmonology |
| **18** | Specialist Physician |
| **19** | Gastroenterology |
| **20** | Neurology |
| **22** | Psychiatry |
| **23** | Rediation/Medical Oncology |
| **24** | Neurosurgery |
| **25** | Nuclear Medicine |
| **26** | Ophthalmology |
| **28** | Orthopedics |
| **30** | Otorhinolaryngology |
| **34** | Physical Medicine |
| **36** | Plastic and Reconstructive Surgery |
| **38** | Diagnostic Radiology |
| **39** | Radiographers |
| **40** | Radiotherapy/Nuclear Medicine/Oncologist |
| **42** | Surgery Specialist |
| **44** | Cardio Thoracic Surgery |
| **46** | Urology |
| **49** | Sub-Acute Facilities |
| **52** | Pathology |
| **54** | General Dental Practice |
| **55** | Mental Health Institutions |
| **56** | Provincial Hospitals |
| **57** | Private Hospitals |
| **58** | Private Hospitals |
| **59** | Private Rehab Hospital (Acute) |
| **60** | Pharmacies |
| **62** | Maxillo-facial and Oral Surgery |
| **64** | Orthodontics |
| **66** | Occupational Therapy |
| **70** | Optometrists |
| **72** | Physiotherapists |
| **75** | Clinical technology (Renal Dialysis only) |
| **76** | Unattached operating theatres / Day clinics |
| 77 | Approved U O T U / Day clinics |
| 78 | Blood transfusion services |
| **82** | Speech therapy and Audiology |
| **86** | Psychologists |
| **87** | Orthotists & Prosthetists |
| **88** | Registered nurses |
| **89** | Social workers |

| | |
|---|---|
| 90 | Manufacturers of assisstive devices |

## TARIFF OF FEES IN RESPECT OF CHIROPRACTIC SERVICES FROM 1 APRIL 2021

## GENERAL RULES GOVERNING THE TARIFF

**001** "After hours treatment" shall mean those performed by arrangement at night between 18:00 and 07:00 on the following day or during weekends between 13:00 Saturday and 07:00 on Monday. Public holidays are regarded as Sundays. This rule shall apply for all treatment whether administered in the practitioner's rooms, or at a nursing home or private residence (only by arrangement when the employee's condition necessitates it).

The fee for all treatment under this rule shall be the total fee for treatment + 50%.

In cases where the chiropractor's scheduled working hours extend after 18:00 during the week or 13:00 on a Saturday the above rule shall not apply and the treatment fee shall be that of the **normal listed tariff**.

**002** ***Travelling fees***

(a) Where, in the case of emergency, a chiropractor is called out from his residence or rooms to an employee's home or the hospital, travelling fees can be charged if more than 16 kilometres in total have to be travelled.

(b) If more than one employee is attended to during the course of a trip, the full travelling expenses must be divided *pro rata* between the relevant employees.

(c) A practitioner is not entitled to charge for any travelling expenses to his rooms.

When a chiropractor has to travel to visit an employee, the fees shall be calculated as follows:

R4.12 per kilometre travelled in **own car.**

**003** If, after a series of 20 treatment sessions for the same condition, further treatment is required, the practitioner must submit a progress report to the Compensation Commissioner indicating the necessity for further treatment and the number of further treatment sessions required. Without such a report payment for treatment sessions in excess of 20 shall not be considered.

**004** The reports for completion by the practitioner:

(a) **The First Medical Report (W.Cl.4)**

The form is used for all injured employees. The practitioner should note that the form is in the nature of a signed medical certificate and he should, therefore, observe due care in completing, dating and signing the form.

(b) **The Progress or Final Medical Report (W.Cl.5)**

This form is used either for progress reports or the final report; the appropriate descriptive title being retained as the case may be. Most of the items in the report are self-explanatory and require no special amplification.

**006** Un-cancelled appointments — Appointments not cancelled at least four hours before the relevant appointment time — relevant practitioner's fees shall be payable by the employee.

**007** **Reports:**

Not applicable in respect of injured workmen covered under the COIDA.

**008** **Change of chiropractor / medical practitioner ("supersession"):**

In the event of a change of chiropractor / medical practitioner consulted, the first chiropractor / medical practitioner in attendance will, except where the case is handed over to a specialist, be regarded as the principal, and payment will normally be made to him / her. To avoid disputes, chiropractors / medical practitioners should refrain from treating a case already under treatment without first discussing it with the first chiropractor / medical practitioner. As a general rule, changes of chiropractor / medical practitioner are not favoured, unless sufficient reasons exist.

## CHIROPRACTOR / CHIROPRAKTISYN 2021

| | | | 2021 |
|---|---|---|---|
| **1** | **CONSULTATIONS / KONSULTASIES** | | |
| | 04301 | Initial consultation — including the taking of a full case history or pertinent history, but excluding remedies,immobilisation and manipulation procedures Consultation includes history taking,guidance,education,health promotion and/or consultation. The consultation code may be charged only once at the consultation or Visit. | R 324.01 |
| **2** | **DIAGNOSTIC PROCEDURES** | | |
| | | Only a single item from this section may be charged per patient encounter. Diagnostic procedures included in the scope of practice are; physical examination, neurological examination **Initial consultation**- charge 04313 (may only be used once per episode of injury ) **Follow up consultation**- use 04311 or 04312 only When using 04312 at a subsequent consultation, a motivation detailing why two diagnostic are requir a follow up treatment. Use form WCL5 to submit your motivation. | |
| | 04311 | Single diagnostic procedure **(May be used with up to three treatment/therapeutic codes)** | R 210.03 |
| | 04312 | Two diagnostic procedures **(Attach Motivation)** | R 319.12 |
| | 04313 | Three diagnostic procedures **(May only be used on an initial Consultation)** | R 420.07 |
| | ***TREATMENT ( THERAPEUTIC PROCEDURES )*** | | |
| | **Only a single item from this section may be charged per patient encounter** | | |
| | 04331 | Single treatment procedure | R 446.12 |
| | 04332 | Two treatment procedures | R 540.55 |
| | 04333 | Three treatment procedures | R 634.99 |
| | 04334 | Four treatment procedures | R 729.42 |
| | 04335 | Five treatment procedures | R 823.86 |
| | 04336 | Six treatment procedures | R 916.66 |
| | ***IMMOBILISATION OR THERAPEUTIC EXERCISE IN RELATION TO PREPARATION OR FITTING OF APPLIANCES*** | | |
| | ***Only a single item from this section may be charged per patient encounter*** | | |
| | 04321 | Single instance of immobilization or therapeutic exercises | R 634.99 |
| | 04322 | Two instances of immobilization or therapeutic exercises **(Attach Motivation )** | R 797.80 |
| (k) | ***RADIOLOGY/RADIOLOGIE*** | | |
| | 04049 | Ankle—AP / LAT• Enkel—AP / LAT | R 259.36 |
| | 04050 | Ankle—Complete Study—3 views• Enkel—Volledige studie—3 aansigte | R 388.29 |
| | 04051 | Cervical—AP / LAT• Servikaal—AP / LAT | R 259.12 |
| | 04052 | Cervical—AP / LAT / OBL• Servikaal—AP / LAT / Skuinsaansigte | R 388.29 |
| | 04053 | Cervical study—6 views• Servikaal—6 aansigte | R 776.62 |
| | 04054 | Cervical—Davis Series—7 views• Servikaal—Davis Series—7 aansigte | R 905.52 |
| | 04055 | Elbow—AP / LAT• Elmboog—AP / LAT | R 254.28 |
| | 04056 | Elbow—3 views• Elmboog—3 aansigte | R 388.29 |
| | 04057 | Foot—AP / LAT• Voet—AP / LAT | R 259.12 |
| | 04058 | Foot—3 views• Voet—3 aansigte | R 388.29 |
| | 04059 | Femur—AP / LAT• Dybeen—AP / LAT | R 517.71 |
| | 04060 | Hand—AP / LAT• Hand—AP / LAT | R 259.12 |
| | 04061 | Hand—3 views• Hand—3 aansigte | R 388.29 |
| | 04062 | Hip unilateral—1 view• Heup—1 aansig | R 181.27 |
| | 04063 | Hip—2 views• Heup—2 aansigte | R 362.27 |
| | 04064 | Knee—AP / LAT• Knie—AP / LAT | R 259.12 |
| | 04065 | Knee—3 views• Knie—3 aansigte | R 388.29 |
| | 04066 | Lumbo-Sacral—3 views• Lumbo-Sakraal—3 aansigte | R 621.13 |
| | 04067 | Lumbar spine & pelvis—5 views• Lumbale werwels & pelvis—5 aansigte | R 931.32 |
| | 04068 | Pelvis AP• Pelvis AP | R 259.12 |

| | | |
|---|---|---|
| 04069 | Pelvis—3 views• Pelvis—3 aansigte | R 569.52 |
| 04070 | Ribs—Unilateral—2 views• Ribbes—Unilateraal—2 aansigte | R 310.44 |
| 04071 | Ribs—Bilateral—3 views• Ribbes—Bilateraal—3 aansigte | R 465.65 |
| 04072 | Radius / Ulna• Radius / Ulna | R 259.12 |
| 04073 | Spine—Full spine study—AP / LAT• Werwelkolom—hele werwelkolom plus pelvis—AP / LAT | R 931.32 |
| 04074 | Spine—8 X 10—Single study• Spinaal—8 X 10—Enkele aansig | R 153.31 |
| 04075 | Spine—10 X 12—Single study• Spinaal—10 X 12—Enkele studie | R 155.48 |
| 04076 | Spine—14 X 17—Single study• Spinaal—14 X 17—Enkele studie | R 259.12 |
| 04077 | Shoulder—1 view• Skouer—1 aansig | R 155.48 |
| 04078 | Shoulder—2 views• Skouer—2 aansigte | R 310.44 |
| 04079 | Thoraco—Lumbar—AP / LAT• Torako—Lumbaal—AP / LAT | R 517.71 |
| 04080 | Thoracic—AP / LAT Torakaal—AP / LAT | R 517.71 |
| 04081 | Tibia/Fibula—AP / LAT• Tibia/Fibula—AP / LAT | R 517.71 |
| 04082 | Wrist—AP / LAT• Gewrig—AP / LAT | R 259.12 |
| 04083 | Wrist—3 views• Gewrig—3 aansigte | R 388.29 |
| 04084 | Stress views—Lumbar• Spanningsopnames—Lumbaal | R 324.67 |
| 04100 | Consumables (claim using Nappi codes) | |

***Radiation Control Council Certificate number to be on account if X-Rays charged***

Claim Number: ----------

# REHABILITATION PROGRESS REPORT

## COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASE ACT

Names and Surname of Employee _____

Identity Number_____ Address_____

_____Postal Code_____

Name of Employer_____

Address_____

_____Postal Code_____

Date of Accident _____

1. Date of first treatment_____ Provider who provided first treatment_____
2. Initial clinical presentation and functional status_____

   _____

   _____
3. Name of referring medical practitioner _____ Date of referral_____
4. Describe patient's current symptoms and functional status_____

   _____

   _____

   _____
5. Are there any complicating factors that may prolong rehabilitation or delay recovery (specify)?_____

   _____

   _____
6. Overall goal of treatment:_____

   _____

   _____
7. Number of sessions already delivered_____ Progress achieved_____

   _____

   _____

   _____

   _____

Claim Number: ----------

8. Number of sessions required_____ Treatment plan for proposed treatment sessions_____

_____

_____

9. From what date has the employee been fit for his/her normal work?_____
10. Is the employee fully rehabilitated / has the employee obtained the highest level of function?_____
11. **If so, describe in detail any present permanent anatomical defect and / or impairment of function as a result of the accident ( R.O.M, if any must be indicated in degrees at each specific joint)**_____

_____

_____

_____

_____

_____

_____

**I certify that I have by examination, satisfied myself that the injury(ies) are as a result of the accident.**

Signature of rehabilitation service provider_____

Name( Printed) _____ Date( Important)_____

Address_____

Practice number_____

**NB: Rehabilitation progress reports must be submitted on a monthly basis and attached to the submitted accounts.**

labour
Department:
Labour
REPUBLIC OF SOUTH AFRICA

# COMPEASY ELECTRONIC INVOICING FILE LAYOUT

| Field | Description | Max length | Data Type |
|---|---|---|---|
| **BATCH HEADER** | | | |
| 1 | Header identifier = 1 | 1 | Numeric |
| 2 | Switch internal Medical aid reference number | 5 | Alpha |
| 3 | Transaction type = M | 1 | Alpha |
| 4 | Switch administrator number | 3 | Numeric |
| 5 | Batch number | 9 | Numeric |
| 6 | Batch date (CCYYMMDD) | 8 | Date |
| 7 | Scheme name | 40 | Alpha |
| 8 | Switch internal | 1 | Numeric |
| **DETAIL LINES** | | | |
| 1 | Transaction identifier = M | 1 | Alpha |
| 2 | Batch sequence number | 10 | Numeric |
| 3 | Switch transaction number | 10 | Numeric |
| 4 | Switch internal | 3 | Numeric |
| 5 | CF Claim number | 20 | Alpha |
| 6 | Employee surname | 20 | Alpha |
| 7 | Employee initials | 4 | Alpha |
| 8 | Employee Names | 20 | Alpha |
| 9 | BHF Practice number | 15 | Alpha |
| 10 | Switch ID | 3 | Numeric |
| 11 | Patient reference number (account number) | 10 | Alpha |
| 12 | Type of service | 1 | Alpha |
| 13 | Service date (CCYYMMDD) | 8 | Date |
| 14 | Quantity / Time in minutes | 7 | Decimal |
| 15 | Service amount | 15 | Decimal |
| 16 | Discount amount | 15 | Decimal |
| 17 | Description | 30 | Alpha |
| 18 | Tariff | 10 | Alpha |
| **Field** | **Description** | **Max length** | **Data Type** |
| 19 | Service fee | 1 | Numeric |
| 20 | Modifier 1 | 5 | Alpha |
| 21 | Modifier 2 | 5 | Alpha |
| 22 | Modifier 3 | 5 | Alpha |
| 23 | Modifier 4 | 5 | Alpha |
| 24 | Invoice Number | 10 | Alpha |
| 25 | Practice name | 40 | Alpha |
| 26 | Referring doctor's BHF practice number | 15 | Alpha |
| 27 | Medicine code (NAPPI CODE) | 15 | Alpha |
| 28 | Doctor practice number -sReferredTo | 30 | Numeric |
| 29 | Date of birth / ID number | 13 | Numeric |
| 30 | Service Switch transaction number – batch number | 20 | Alpha |
| 31 | Hospital indicator | 1 | Alpha |
| 32 | Authorisation number | 21 | Alpha |
| 33 | Resubmission flag | 5 | Alpha |
| 34 | Diagnostic codes | 64 | Alpha |

| | | | |
|---|---|---|---|
| 35 | Treating Doctor BHF practice number | 9 | Alpha |
| 36 | Dosage duration (for medicine) | 4 | Alpha |
| 37 | Tooth numbers | | Alpha |
| 38 | Gender (M ,F ) | 1 | Alpha |
| 39 | HPCSA number | 15 | Alpha |
| 40 | Diagnostic code type | 1 | Alpha |
| 41 | Tariff code type | 1 | Alpha |
| 42 | CPT code / CDT code | 8 | Numeric |
| 43 | Free Text | 250 | Alpha |
| 44 | Place of service | 2 | Numeric |
| 45 | Batch number | 10 | Numeric |
| 46 | Switch Medical scheme identifier | 5 | Alpha |
| 47 | Referring Doctor's HPCSA number | 15 | Alpha |
| 48 | Tracking number | 15 | Alpha |
| 49 | Optometry: Reading additions | 12 | Alpha |
| 50 | Optometry: Lens | 34 | Alpha |
| 51 | Optometry: Density of tint | 6 | Alpha |
| 52 | Discipline code | 7 | Numeric |
| 53 | Employer name | 40 | Alpha |
| 54 | Employee number | 15 | Alpha |

| Field | Description | Max length | Data Type |
|---|---|---|---|
| 55 | Date of Injury (CCYYMMDD) | 8 | Date |
| 56 | IOD reference number | 15 | Alpha |
| 57 | Single Exit Price (Inclusive of VAT) | 15 | Numeric |
| 58 | Dispensing Fee | 15 | Numeric |
| 59 | Service Time | 4 | Numeric |
| 60 | | | |
| 61 | | | |
| 62 | | | |
| 63 | | | |
| 64 | Treatment Date from (CCYYMMDD) | 8 | Date |
| 65 | Treatment Time (HHMM) | 4 | Numeric |
| 66 | Treatment Date to (CCYYMMDD) | 8 | Date |
| 67 | Treatment Time (HHMM) | 4 | Numeric |
| 68 | Surgeon BHF Practice Number | 15 | Alpha |
| 69 | Anaesthetist BHF Practice Number | 15 | Alpha |
| 70 | Assistant BHF Practice Number | 15 | Alpha |
| 71 | Hospital Tariff Type | 1 | Alpha |
| 72 | Per diem (Y/N) | 1 | Alpha |
| 73 | Length of stay | 5 | Numeric |
| 74 | Free text diagnosis | 30 | Alpha |

**TRAILER**

| | | | |
|---|---|---|---|
| 1 | Trailer Identifier = Z | 1 | Alpha |
| 2 | Total number of transactions in batch | 10 | Numeric |
| 3 | Total amount of detail transactions | 15 | Decimal |

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