533	45 minutes	04.00							
535	60 minutes	04.00							
537	75 minutes	04.00							
539	90 minutes	04.00							
541	105 minutes	04.00							
543	120 minutes	04.00							
Staff and Consumables									
581	30 minutes	04.00							
583	45 - 75 minutes	04.00							
585	90 - 105 minutes	04.00							
587	120 minutes	04.00							
Aircraft Type D									
591	Hourly rate plus 20%	04.00							
Winching									
595	Winching, per lift	04.00							
Fixed Wing Rates									
	DEFINITIONS: 1. Group A must fall within the Cat 138 Ops as determined by Civil Aviation. 2. No fee structure has been provided for Group B, as emergency charters could include any form of aircraft. It would be impossible to specify costs over such a broad range. These can only be used during emergencies when no Group A aircraft are available. 3. Staff and consumables cost can only be used if the patient has been treated. 4. 2nd patient transferred at 50% reduction of Basic Call and Flight Cost, but Staff and consumables costs remain per patient. (only if aircraft capability allows for multiple patients)								04.00
Group A (FA)									
	Composed of flying cost per kilometer, staff cost per hour and equipment cost								04.00
Staff cost per hour									
621	Doctor	04.00							
623	ICU Sister	04.00							
625	Paramedic	04.00							
Equipment Cost									
631	Per patient, per hour	04.00							
Aircraft cost (per kilometer)									
651	Beechcraft Duke	04.00							
653	Lear 24F	04.00							
655	Lear 35	04.00							
657	Falcon 10	04.00							
659	King Air 200	04.00							

661	Mitsubishi MU2	04.00							
663	Cessna 402	04.00							
665	Beechcraft Baron	04.00							
667	Citation II	04.00							
669	Pilatus PC12	04.00							
Group B - Emergency Charters									
	1. No staff and equipment fee allowed. 2. Cost to be reviewed per case. 3. Only allowed if a Group A aircraft is not available within an optimal period for transportation and stabilisation of the patient.								04.00
6	**NATIONALLY APPROVED MEDICATIONS WHICH MAY BE ADMINISTERED BY HPCSA-REGISTERED AMBULANCE PERSONNEL ACCORDING TO HPCSA-APPROVED PROTOCOLS**								
	Registered Basic Ambulance Assistant Qualification · Oxygen · Entonox · Oral Glucose Registered Ambulance Emergency Assistant Qualification As above, plus · Intravenous fluid therapy · Intravenous dextrose 50% · B2 stimulant nebuliser inhalant solutions (Hexoprenaline, Fenoterol, Sulbutamol) · Soluble Aspirin Registered Paramedic Qualification As above, plus · Oral glyceryl trinitrate, activated charcoal · Ipratropium bromide inhalant solution · Endotracheal Adrenaline and Atropine · Intravenous Adrenaline, Atropine, Calcium, Hydrocortisone, Lignocaine, Naloxone, Sodium bicarbonate, Hetaclopramide · Intravenous Diazepam, Flumazenil, Furosemide, Hexoprenaline, Midazolam, Nalbuphine and Tramadol may only be administered after permission has been obtained from the relevant supervising medical officer. · Pacing and synchronised cardioversion require the permission of the relevant supervising medical officer.								04.00

SERVICES BY HOSPITALS		
GENERAL RULES		
SCHEDULE		
B	The charges relating to each type of hospital/unattached operating theatre unit are indicated in the relevant column opposite the item codes.	04.00
C	The charges indicated in Section 5 hereof, are applicable to both categories of such hospitals and unattached operating theatre units.	04.00
D	When drugs, consumables and disposable items are used during a procedure, or issued to a patient on discharge, the Fund shall only reimburse the cost of such items, in line with this tariff, if the appropriate code is supplied on the account.	04.00
E.1	Procedure for the classification of hospitals:	04.00
E.1.1	Inspections of private hospitals or unattached operating theatre units/day clinics having practice code numbers commencing with the digits 057, 058 or 077 will be conducted by an independent agency on behalf of the BHF. Applications to be addressed in writing to the BHF.	04.00
E.3.2	The provisions referred to in E.1.1 shall apply mutatis mutandis to all approved specialised intensive care units, specialised theatres, catheterisation laboratories and trauma units.	04.00
F.1	Procedures to consider applications by institutions to be classified as unattached operating theatre units having a practice code number commencing with the digits 77 and for the reclassification of unattached operating theatre units with 76 practice numbers.	04.00
F.1.1	Inspections of new unattached theatre operating units and units having practice code numbers commencing with the digit 76, to be reclassified as approved unattached operating theatre units having practice numbers commencing with the digits 77 will be conducted by an independent agency on behalf of the BHF. Applications to be addressed in writing to the BHF.	04.00
G	All accounts submitted by private and unattached operating theatre units/day clinics shall comply with all of the requirements in terms of the Medical Schemes Act, Act No. 131 of 1999. Where possible, such accounts shall also reflect the practice code numbers and names of the surgeon, the anaesthetist and of any assistant surgeon who may have been present during the course of an operation.	04.00
H	All accounts shall be accompanied by a copy of the relevant theatre accounts specifying all details of items charged, as well as all the procedures performed. Photocopies of all other documents pertaining to the patients account must be provided on request. The Fund shall have the right to inspect the original source documents at the hospital/unattached operating theatre unit concerned.	04.00
I	All accounts containing items which are subject to a discount shall indicate such items individually and shall show separately the gross amount of the discount.	04.00

1	ACCOMMODATION	
Ward fees		
	Hospitals and unattached operating theatre units shall indicate the exact time of admission and discharge on all accounts. In the case of hospitals, the day admission fee (code 007) shall be charged in respect of all patients admitted as day patients and discharged before 23h00 on the same date. The following will be applicable to items 001 to 005, 015, 020, 200, 201, 202 and 215 to 218: On the day of admission: If accommodation is less than 12 hours from time of admission : half the daily rate If accommodation is more than 12 hours from time of admission: full daily rate Two half day fees would be applicable when a patient is transferred internally between any ward and any specialised unit. On day of discharge: If accommodation is less than 12 hours: half the daily rate If accommodation is more than 12 hours: full daily rate The items listed as non-recoverable in Annuxure B shall be deemed to be included in ward fees, and no charge in respect thereof may be levied.	04.00

1.1	General Wards									
Code	**Description**	**Ver**	**Add**	**Private Hospitals ('A' - Status)**		**Private Hospitals ('B' - Status)**		**Approved U O T U / Day clinics**		
				RVU	**Fee**	**RVU**	**Fee**	**RVU**	**Fee**	
001	Surgical cases: per day.	04.00		36.063	907.90 (796.40)	36.063	907.90 (796.40)	-	-	
002	Thoracic and neurosurgical cases (including laminectomies and spinal fusion): per day	04.00		37.888	953.90 (836.80)	37.888	953.90 (836.80)	-	-	
005	Paediatric cases (under 14 years of age)	04.00		44.513	1120.70 (983.10)	44.513	1120.70 (983.10)	-	-	
	Day admissions - all patients admitted as day patients and discharged before 23h00 on the same day	04.00								
007	Day admission (irrespective of type of ward patient is admitted to, i.e. general, neurosurgical or paediatric) which includes all patients discharged by 23h00 on date of admission	04.00		23.079	581.00 (509.60)	23.079	581.00 (509.60)	19.725	496.60 (435.60)	
014	Overnight fee - Medical practitioner to pre-authorise all overnight admissions	04.00		-	-	-	-	8.692	218.80 (191.90)	
Natural births										
009	First day (Day of confinement).	04.00		174.458	4392.20 (3852.80)	174.458	4392.20 (3852.80)	-	-	
010	Subsequent day(s).Per day	04.00		60.096	1513.00 (1327.20)	60.096	1513.00 (1327.20)	-	-	

Caesarean									
012	First day (Day of confinement).	04.00		270.992	6822.50 (5984.60)	270.992	6822.50 (5984.60)	-	-
013	Subsequent day(s). Per day	04.00		59.583	1500.10 (1315.90)	59.583	1500.10 (1315.90)	-	-
	Note: The following fees (items 015 and 016) are included in the above per diem fees, and may only be charged on a fee for service account	04.00							
015	Nursery fee.	04.00		16.925	426.10 (373.80)	16.925	426.10 (373.80)	-	-
016	Delivery room. This item is not applicable for deliveries by registered midwifes in private practice.	05.03		72.746	1831.50 (1606.60)	72.746	1831.50 (1606.60)	-	-
018	Subsequent day(s) excluding nursery fee	04.00		42.963	1081.60 (948.80)	42.963	1081.60 (948.80)	-	-
Epidural fee									
011	Use of epidural anaesthesia for MATERNITY CASES ONLY. (Note: This item includes all surgicals and nursing but no ethicals)	04.00		26.500	667.20 (585.30)	26.500	667.20 (585.30)	-	-
1.2	**Private Wards**								
020	Private ward Hospitals shall obtain a certificate motivating for the necessity for accommodation in a private ward, from the attendant practitioner, and such certificate shall be forwarded to the Fund for pre-authorisation. General ward fees are applicable to isolation.	04.00		46.608	1173.40 (1029.30)	46.608	1173.40 (1029.30)	-	-
021	Private ward on member's request or for convenience of hospital will be funded at scale of benefits for general ward.	04.00		-	-	-	-	-	-
1.3	**Special Care Units**								
	Specialised units are defined as: Intensive Care Unit (ICU), Cardio-Thoracic Intensive Care Unit (CTICU), Neonatal Intensive Care Unit (NICU), High Care (HC), Neonatal High Care (NHC), A & B.	04.00							
	Hospitals shall obtain a certificate stating the reason for accommodation in any specialised or other intensive care unit or in high care ward including neonatal intensive care and high care from the attending practitioner, and such certificate showing the date and time of admission and discharge from the unit shall be forwarded to the Fund. No charge may be levied to the Fund for special or private nursing.	04.00							
200	Specialised ICU per day	04.00		195.088	4911.50 (4308.30)	195.088	4911.50 (4308.30)	-	-
	(Subject to a maximum of 1 day. Pre-authorisation required for every additional day thereafter. Item 201 will apply if no pre-authorisation is obtained. Use of this unit shall be limited to cardio-thoracic surgery, major vascular surgery and neuro-surgery cases involving surgery on the brain and spinal cord).	04.00							

201	Intensive Care Unit: Per day.	04.00		148.479	3738.10 (3279.00)	148.479	3738.10 (3279.00)	-	-
202	Neonatal Intensive Care Unit: Per day.	04.00		184.863	4654.10 (4082.50)	184.863	4654.10 (4082.50)	-	-
	(The charges referred to under items 200, 201 and 202 include the use of all equipment except: Bennett MA, Servo and Bear ventilators or equivalent apparatus plus the cost of oxygen)	04.00							
215	High Care Ward, Per day.	04.00		95.108	2394.40 (2100.40)	95.108	2394.40 (2100.40)	-	-
216	Neonatal High Care Ward `A' (Intensive nursing and monitoring)	04.00		103.308	2600.90 (2281.50)	103.308	2600.90 (2281.50)	-	-
217	Neonatal High Care Ward `B' (Standard nursing and monitoring)	04.00		67.538	1700.30 (1491.50)	67.538	1700.30 (1491.50)	-	-
	Note: Once the baby has been stabilised and no longer requires ICU care but is not ready to be returned to the general nursery, no additional equipment charges, eg phototherapy may be charged. All admissions to units/wards referred to under 201 to 202 shall be confirmed with the Fund for each 72 hours and 215 to 218 shall be confirmed weekly.	04.00							
2	**EMERGENCY UNIT**								
2.1	**Emergency Unit Fee**								
105	Resuscitation fee charged only if patient has been resuscitated and intubated in a trauma unit.	04.00		45.858	1154.50 (1012.70)	45.858	1154.50 (1012.70)	-	-
302	For all consultations which require the use of a procedure room or nursing input, e.g. for application of plaster of Paris, stitching of wounds, insertion of IV Therapy. Includes the use of the procedure room. No per minute charge may be levied.	04.00		10.533	265.20 (232.60)	10.533	265.20 (232.60)	10.533	265.20 (232.60)
	Note: The procedure room fee (071) cannot be charged in addition to 302	04.00							
2.2	**THEATRE FEES**								
061	Excimer Laser Theatre fee, per minute	04.00		0.650	16.40 (14.40)	0.650	16.40 (14.40)	0.650	16.40 (14.40)
	Items listed as non-recoverable per Annuxure B of the National Health Reference Price List (in respect of Private Hospitals) shall be deemed to be included in theatre fees, and no charge in respect thereof may be levied.	04.00							
2.3	**Major theatre**								
	In addition to the theatre charge calculated as above, a surcharge (modifier 0002 and/or 0003) shall be allowed in cases where specialised theatres referred to in General Rule E.1.1 are utilised for the performance of any of the undermentioned procedures, whether carried out individually or in combination with each other, this surcharge shall be deemed to cover the equipment in the criteria. Note: Specialised intensive care units and specialised theatres are to be individually inspected and approved by the BHF	04.00							
0002	Modifier 0002: Orthopaedic, Neurosurgical and Vascular: · Femoro- popliteal bypasses · Neurosurgery (Surgery on the brain and spinal cord only, excludes neurolysis)	04.00		48.309	1216.23 (1066.87)	48.309	1216.23 (1066.87)	-	-

0003	Modifier 0003: Cardiac surgery Cardio-thoracic and Cardio-vascular surgery · All open heart surgery, with or without the insertion of a prosthesis, coronary artery bypass grafts and heart transplants. Includes all equipment (except item 513), no additional fees may be charged NOTE: The above surcharge will also be applicable to approved provincial hospitals	04.00		110.688	2786.68 (2444.46)	110.688	2786.68 (2444.46)	-	-
Time in Theatre									
081	Charge per minute (which includes 0.16c per minute for those items in the surgical basket).	04.00		1.554	39.10 (34.30)	1.554	39.10 (34.30)	1.329	33.50 (29.40)
	The exact time of admission to and discharge from theatre shall be stated, upon which the theatre charge shall be calculated as follows	04.00							
Specialised Theatre Modifiers									
3	**PROCEDURAL FEES**								
	The fees quoted for items 052, 053 and 055 shall be all-inclusive and no additional charges of whatsoever nature may be raised, except for items 515, 529, 533, 535 and any items chargeable in terms of Section 4 and 5 hereof. NOTE: Ward fees may however be chargeable together with items 053 and 055.								05.03
3.1	**Procedures**								
052	Procedures carried out in X-ray department using hospital owned equipment under general anaesthetic.	04.00		14.342	361.10 (316.80)	14.342	361.10 (316.80)	14.342	361.10 (316.80)
053	Angiograms.	04.00		14.342	361.10 (316.80)	14.342	361.10 (316.80)	-	-
3.2	**Catheterisation laboratory procedures**								
	Note: A certificate indicating the level of the catheterisation laboratory used, should be signed by the relevant doctor, indicating the information if required by the Fund.								05.03
	The fees quoted for items 054, 056, 070 and 073 shall be all-inclusive and no additional charges of whatsoever nature may be raised, except for items 515, 529, 533 and 535 and any items chargeable in terms of Section 4 and 5 hereof. NOTE: ward fees may however be chargeable together with items 054, 055, 056, 070 and 073.								05.03
054	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised analogue monoplane unit, and in a hospital equipped to perform the relevant surgery, as approved by the committee established in terms of General Rule E.1.1 NB: For EPS studies, the Bard Apparatus (item 529) must be charged additionally.	04.00		51.446	1295.20 (1136.10)	51.446	1295.20 (1136.10)	-	-
056	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised analogue bi-plane unit, and in a hospital equipped to perform the relevant surgery, as approved by the committee established in terms of General Rule E.1.1	04.00		96.929	2440.30 (2140.60)	96.929	2440.30 (2140.60)	-	-

070	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised digital bi-plane unit, and in a hospital equipped to perform the relevant surgery, as approved by the committee established in terms of General Rule E.1.1. NB: EPS for cardiac ablations - items 529 must be charged additionally.	04.00		251.804	6339.40 (5560.90)	251.804	6339.40 (5560.90)	-	-
073	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised digital monoplane unit, and in a hospital equipped to perform the relevant surgery, as approved by the committee established in terms of General Rule E.1.1	04.00		186.233	4688.60 (4112.80)	186.233	4688.60 (4112.80)	-	-
075	Catheterisation laboratory film price (once per procedure)	04.00		5.546	139.60 (122.50)	5.546	139.60 (122.50)	-	-
3.3	**Stereotactic radiosurgery**								
	Included in item 430 Stereotactic frames and attachments Linear Accelerator Specialised graphic planning, hardware and software Simulator and dark rooms Stereotactic masks All disposables 4 to 20 Graphic transparencies (including 1 week of planning) 2 trained radiographers Fixation and immobilisation Nuclear Specialist Medical Physicist Duration 1 - 4 hours 2 treatment radiographers Excluded from fee Other medical practitioners CT & MRI								04.00
	Item 399 is an all- inclusive single global radiosurgery fee, payable to a hospital. This item includes item 430, all imaging and all clinical fees. The hospital is responsible for reimbursement of all fees to all the professional providers of service involved in the treatment rendered under this item.	04.00							
430	Global fee for stereotactic radiosurgery	04.00		2520.600	63458.60 (55665.40)	2520.600	63458.60 (55665.40)	-	-
4	**STANDARD CHARGES FOR EQUIPMENT**								
4.1	**Gases**								
	Price increases: Should a change occur in the manufacturer's price of any item listed hereunder, the new price shall be as notified								04.00
Oxygen and Nitrous Oxide									
	For both gases together, per minute								04.00
283	PWV area	04.00		0.110	2.77 (2.43)	0.110	2.77 (2.43)	0.110	2.77 (2.43)

701	Cape Town	04.00		0.151	3.80 (3.33)	0.151	3.80 (3.33)	0.151	3.80 (3.33)
702	Port Elizabeth	04.00		0.134	3.37 (2.96)	0.134	3.37 (2.96)	0.134	3.37 (2.96)
703	East London	04.00		0.149	3.75 (3.29)	0.149	3.75 (3.29)	0.149	3.75 (3.29)
704	Durban	04.00		0.138	3.47 (3.04)	0.138	3.47 (3.04)	0.138	3.47 (3.04)
705	Other areas	04.00		0.123	3.10 (2.72)	0.123	3.10 (2.72)	0.123	3.10 (2.72)
Oxygen, ward use									
	Fee for oxygen, per quarter hour or part thereof, outside the operating theatre complex								04.00
284	PWV area	04.00		0.162	4.08 (3.58)	0.162	4.08 (3.58)	0.162	4.08 (3.58)
710	Cape Town	04.00		0.268	6.75 (5.92)	0.268	6.75 (5.92)	0.268	6.75 (5.92)
711	Port Elizabeth	04.00		0.258	6.50 (5.70)	0.258	6.50 (5.70)	0.258	6.50 (5.70)
712	East London	04.00		0.248	6.24 (5.47)	0.248	6.24 (5.47)	0.248	6.24 (5.47)
713	Durban	04.00		0.210	5.29 (4.64)	0.210	5.29 (4.64)	0.210	5.29 (4.64)
714	Other areas	04.00		0.200	5.04 (4.42)	0.200	5.04 (4.42)	0.200	5.04 (4.42)
Oxygen, recovery room or emergency room									
	Flat rate for oxygen per case								04.00
720	PWV area	04.00		0.322	8.11 (7.11)	0.322	8.11 (7.11)	0.322	8.11 (7.11)
721	Cape Town	04.00		0.533	13.40 (11.80)	0.533	13.40 (11.80)	0.533	13.40 (11.80)
722	Port Elizabeth	04.00		0.513	12.90 (11.30)	0.513	12.90 (11.30)	0.513	12.90 (11.30)
723	East London	04.00		0.492	12.40 (10.90)	0.492	12.40 (10.90)	0.492	12.40 (10.90)
724	Durban	04.00		0.421	10.60 (9.30)	0.421	10.60 (9.30)	0.421	10.60 (9.30)
725	Other areas	04.00		0.398	10.00 (8.77)	0.398	10.00 (8.77)	0.398	10.00 (8.77)
Oxygen in Theatre									
	Fee for oxygen per minute in the operating theatre when no other gas administered								04.00
730	PWV area	04.00		0.010	0.25 (0.22)	0.010	0.25 (0.22)	0.010	0.25 (0.22)
731	Cape Town	04.00		0.018	0.45 (0.39)	0.018	0.45 (0.39)	0.018	0.45 (0.39)
732	Port Elizabeth	04.00		0.017	0.43 (0.38)	0.017	0.43 (0.38)	0.017	0.43 (0.38)
733	East London	04.00		0.017	0.43 (0.38)	0.017	0.43 (0.38)	0.017	0.43 (0.38)
734	Durban	04.00		0.013	0.33 (0.29)	0.013	0.33 (0.29)	0.013	0.33 (0.29)
735	Other areas	04.00		0.013	0.33 (0.29)	0.013	0.33 (0.29)	0.013	0.33 (0.29)
Carbon Dioxide									
291	Per minute	04.00		0.020	0.50 (0.44)	0.020	0.50 (0.44)	0.020	0.50 (0.44)
Laser Mix									
292	Per minute	04.00		0.387	9.74 (8.54)	0.387	9.74 (8.54)	0.387	9.74 (8.54)

Entonox									
293	Per 30 minutes	04.00		3.675	92.50 (81.10)	3.675	92.50 (81.10)	3.675	92.50 (81.10)
5	**Inhalation anaesthetics**								
	Price increases: Should a change occur in the manufacturer's price of any item listed hereunder, the new price shall be as notified								04.00
285	Halothane (Halothane): per minute	04.00		0.041	1.03 (0.90)	0.041	1.03 (0.90)	0.041	1.03 (0.90)
752	Ethrane (Enflurane): per minute	04.00		0.218	5.49 (4.82)	0.218	5.49 (4.82)	0.218	5.49 (4.82)
753	Forane (Isoflurane): per minute	04.00		0.205	5.16 (4.53)	0.205	5.16 (4.53)	0.205	5.16 (4.53)
754	Isofor (Isoflurane): per minute	04.00		0.186	4.68 (4.11)	0.186	4.68 (4.11)	0.186	4.68 (4.11)
755	Ultane (Sevoflurane): per minute	04.00		0.376	9.47 (8.31)	0.376	9.47 (8.31)	0.376	9.47 (8.31)
756	Suprane (Desflurane), per minute	04.00		0.320	8.06 (7.07)	0.320	8.06 (7.07)	0.320	8.06 (7.07)
757	Aerrane (Isoflurane): per minute	04.00		0.167	4.20 (3.68)	0.167	4.20 (3.68)	0.167	4.20 (3.68)
758	Alyrane (Enflurane): per minute	04.00		0.168	4.23 (3.71)	0.168	4.23 (3.71)	0.168	4.23 (3.71)
759	Fluothane (Halothane), per minute	04.00		0.040	1.01 (0.89)	0.040	1.01 (0.89)	0.040	1.01 (0.89)

SERVICES BY RADIOLOGISTS

This schedule is for the exclusive use of registered specialist radiology practices (Pr No "038") and nuclear medicine practices (Pr No "025"). "025" practices may only charge the codes with a 3rd digit of 9. "038" practices may charge all codes except codes with a 3rd digit of 9. Practitioners registered as both radiologists and nuclear physicians may charge all codes.

This schedule must be used in conjunction with the Radiological Society of S A Guidelines.

Code Structure Framework

a. The tariff code consists of 5 digits

i. 1st digit indicates the main anatomical region or procedural category.

- 0 = General (non specific)
- 1 = Head
- 2 = Neck
- 3 = Thorax
- 4 = Abdomen and Pelvis (soft tissue)
- 5 = Spine, Pelvis and Hips
- 6 = Upper limbs
- 7 = Lower limbs
- 8 = Interventional
- 9 = Soft tissue regions (nuclear medicine)

eg "Head" = 1xxxx

ii. 2nd digit indicates the sub region within a main region or category

eg. "Head / Skull and Brain" = 10xxx

iii. 3rd digit indicates modality

- 1 = General (Black and White) x-rays
- 2 = Ultrasound
- 3 = Computed Tomography
- 4 = Magnetic Resonance Imaging
- 5 = Angiography
- 6 = Interventional radiology
- 9 = Nuclear Medicine (Isotopes)

eg: "Head / Skull and Brain / General x-ray" = 101xx

iv. 4th and 5th digits are specific to a procedure / examination

eg. "Head / Skull and Brain / General / X-ray of the skull" = 10100.

Guidelines for use of coding structure

- The vast majority of the codes describe complete procedures / examination and their use for the appropriate studies is self-explanatory.
- Some codes may have multiple applications and their use is described in notes associated with each code
- Codes 00510 to 00560 (Angiography machine codes) may only be used by owners of the equipment and who have registered such equipment with the Board of Healthcare Funders / RSSA.
- The machine codes 00510, 00520, 00530, 00540, 00550, 00560 may not be added to 60540, 60550, 70530, 70535 (Antegrade Venography, upper and lower limbs)
- Where public sector hospital equipment is used for a procedure, the units will be reduced by 33.33%.

Consumables

- Contrast Medium
  - Prior to the implementation of Act 90, contrast will be billed according to the official 2004 RSSA reimbursement price list, without mark up.
  - After the implementation of Act 90, contrast medium will be billed according to the suppliers' list price, without mark up.
- Angiography catheters, angioplasty balloons, stents, coils and other embolisation materials, guide wires and drains are to be billed at net acquisition cost, without mark up, until the implementation of Act 90.
- All other consumables are to be billed at net acquisition price, until the implementation of Act 90. Thereafter Act 90 regulations apply.
- The cost of film is included in the comprehensive procedure codes and is not billed for separately.
- Appropriate codes must be provided for consumables.

General Comments on Procedural Codes

- All x-ray tomography codes are stand alone studies and may be used as a unique study or in combination with the appropriate regional study if done simultaneously. May not be added to 20130, 42110, 42115.
- Setting of sterile tray is included in all appropriate procedure codes.
- Where introduction of contrast is necessary eg. angiography, etc, the codes used for the procedures are comprehensive and include the introduction of contrast or isotopes.
- The use of Doppler or Colour Doppler as an adjunct to a study (eg small parts thyroid) is included in the code for that study.
- CT Angiography (10330, 20330, 32300, 32310, 44300, 44310, 44320, 44330, 60310, 70310, 70320) are stand alone studies and may not be added to the regional contrasted studies (see 10335, 20340, 20350, 44325 for combined studies).
- Angiography and interventional procedures include selective and super selective catheterization of vessels as are necessary to perform the procedures.

Codes 00230 (Ultrasound guidance), 00320 (CT guidance) and 00430 (MR guidance) are stand alone procedures that include the regional study and may not be added to any of the ultrasound, CT or MR regional studies

General Codes

Modifiers

Code	Description	Ver
00091	Radiology and nuclear medicine services rendered to hospital inpatients	04.00
00093	A reduction of one third (33.33%) will apply to radiological examinations where hospital equipment it used	04.00

Equipment / Diagnostic

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
00090	Consumables used in radiology procedures: cost price PLUS 26% (up to a maximum of R26,00). (Where applicable, VAT should be added to the above).	05.04				-	-
	Appropriate code to be provided. See separate codes for contrast and isotopes	04.00					
00130	X-ray with mobile unit in other facility	04.00				1.900	115.30 (101.10)
	To be added to applicable procedure codes eg 30100.	04.00					
00135	X-ray control view in theatre any region	04.00				5.260	319.10 (279.90)

Code	Description					Units	Fee
Call and assistance							
	• Emergency call out code 01010 only to be used if radiologist is called out to the rooms to report on an examination after normal working hours. May not be used for routine reporting during extended working hours. • Emergency call out code 01020 only to be used when a radiologist reports on subsequent cases after having been called out to the rooms to report an initial after hours procedure. This code may also be used for home tele-radiology reporting of an emergency procedure. May not be used for routine reporting during normal or extended working hours. • Radiologist assistance in theatre code 01030 only to be used if the radiologist is actively involved in assisting another radiologist or clinician with a procedure. • Radiographer assistance in theatre 01040 may not be used for procedures performed in facilities owned by the radiologist; ie only for attendance in hospital theatres etc. Does not apply to Bed Side Unit (BSU) examinations. • Second opinion consultations only to be used if a written report is provided as indicated in codes 01050, 01055, 01060. Not intended for ad hoc verbal consultations.	05.05					
01010	Emergency call out fee, first case	04.00				3.000	182.00 (159.60)
01020	Emergency call out fee, subsequent cases same trip	04.00				2.000	121.30 (106.40)
01030	Radiologist assistance in theatre, per half hour	04.00				6.000	364.00 (319.30)
01040	Radiographer attendance in theatre, per half hour	04.00				1.600	97.10 (85.20)
01200	Ultrasound procedure after hours, per procedure	04.00				4.000	-
Monitoring							
	• ECG / Pulse oximetry monitoring (02010). Use for monitoring patients requiring conscious sedation during imaging procedure. Not to be used as a routine.	04.00					
02010	ECG/pulse oximeter monitoring	04.00				2.000	121.30 (106.40)
Head							
Skull and Brain							
	Codes 10100 (skull) and 10110 (tomography) may be combined.	04.00					
10100	X-ray of the skull	04.00				3.860	234.20 (205.40)
10110	X-ray tomography of the skull	04.00				4.300	260.80 (228.80)
10200	Ultrasound of the brain – Neonatal	04.00				7.380	447.70 (392.70)
10210	Ultrasound of the brain including doppler	04.00				13.220	802.00 (703.50)
10220	Ultrasound of the intracranial vasculature, including B mode, pulse and colour doppler	04.00				15.040	912.40 (800.40)
10300	CT Brain uncontrasted	04.00				22.650	1374.00 (1205.30)
10310	CT Brain with contrast only	04.00				33.280	2018.80 (1770.90)
10320	CT Brain pre and post contrast	04.00				40.480	2455.60 (2154.00)
10325	CT brain pre and post contrast for perfusion studies	05.03				49.100	2978.50 (2612.70)

Code	Description					Units	Amount
Cervical							
	Code 51100 (stress) is a stand alone study and may not be added to 51110, 51120 (cervical spine), 51160 (myelography) and 51170 (discography). Code 51140 (tomography) may be combined with 51110 or 51120 (spine). Code 51160s (myelography) and 51170 (discography) include fluoroscopy and introduction of contrast (00140 may not be added). Code 51300 (CT) limited - limited to a single cervical vertebral body. Code 51310 (CT) regional study - 2 vertebral bodies and intervertebral disc spaces. Code 51320 (CT) complete study - an extensive study of the cervical spine. Code 51340 (CT myelography) – post myelographic study and includes all disc levels, includes fluoroscopy and introduction of contrast (00140 may not be added).	04.00					
51100	X-ray of the cervical spine, stress views only	04.00				4.140	251.10 (220.30)
51110	X-ray of the cervical spine, one or two views	04.00				3.010	182.60 (160.20)
51120	X-ray of the cervical spine, more than two views	04.00				4.280	259.60 (227.70)
51130	X-ray of the cervical spine, more than two views including stress views	04.00				7.580	459.80 (403.30)
51310	CT of the cervical spine – regional study	04.00				13.91 0	843.80 (740.20)
51320	CT of the cervical spine – complete study	04.00				37.13 0	2252.40 (1975.80)
51330	CT of the cervical spine pre and post contrast	04.00				58.85 0	3570.00 (3131.60)
51340	CT myelography of the cervical spine	04.00				47.19 0	2862.60 (2511.10)
51350	CT myelography of the cervical spine following myelogram	04.00				21.69 0	1315.80 (1154.20)
51400	MR of the cervical spine, limited study	04.00				44.40 0	2693.40 (2362.60)
51410	MR of the cervical spine and cranio-cervical junction	04.00				64.82 0	3932.10 (3449.20)
51420	MR of the cervical spine and cranio-cervical junction pre and post contrast	04.00				102.1 40	6196.00 (5435.10)
Thoracic							
	Code 52120 (tomography) may be combined with 52100 or 52110 (spine). Code 52150 (myelography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 52300 (CT) limited study – limited to a single thoracic vertebral body. Code 52305 (CT) regional study - 2 vertebral bodies and intervertebral disc paces. Code 52310 (CT) complete study - an extensive study of the thoracic spine. Code 52330 (CT myelography) - post myelographic study and includes all disc levels, fluoroscopy and introduction of contrast (00140 may not be added).	04.00					
52100	X-ray of the thoracic spine, one or two views	04.00				3.210	194.70 (170.80)
52110	X-ray of the thoracic spine, more than two views	04.00				4.000	242.60 (212.80)

52120	X-ray tomography thoracic spine	04.00				4.300	260.80 (228.80)
52140	X-ray of the thoracic spine, more that two views including stress views	04.00				6.640	402.80 (353.30)
52305	CT of the thoracic spine – regional study	04.00				13.910	843.80 (740.20)
52310	CT of the thoracic spine complete study	04.00				35.780	2170.50 (1903.90)
52320	CT of the thoracic spine pre and post contrast	04.00				58.850	3570.00 (3131.60)
52330	CT myelography of the thoracic spine	04.00				48.090	2917.20 (2558.90)
52340	CT myelography of the thoracic spine following myelogram	04.00				20.370	1235.70 (1083.90)
52400	MR of the thoracic spine, limited study	04.00				46.600	2826.80 (2479.60)
52410	MR of the thoracic spine	04.00				64.340	3903.00 (3423.70)
52420	MR of the thoracic spine pre and post contrast	04.00				101.420	6152.30 (5396.80)
Lumbar							
	Code 53100 (stress) is a stand alone study and may not be added to 53110, 53120 (lumbar spine), 53160 (myelography) and 53170 (discography). Code 53140 (tomography) may be combined with 53110 or 53120 (spine). Codes 53160 (myelography) and 53170 (discography) include fluoroscopy and introduction of contrast (00140 may not be added). Code 53300 (CT) limited study – limited to a single lumbar vertebral body. Code 53310 (CT) regional study - 2 vertebral bodies and intervertebral disc spaces. Code 53320 (CT) complete study - an extensive study of the lumbar spine. Code 53340 (CT myelography) - post myelographic study and includes all disc levels, fluoroscopy and introduction of contrast (00140 may not be added).	04.00					
53110	X-ray of the lumbar spine, one or two views	04.00				3.560	216.00 (189.50)
53120	X-ray of the lumbar spine, more than two views	04.00				4.460	270.60 (237.40)
53130	X-ray of the lumbar spine, more that two views including stress views	04.00				7.520	456.20 (400.20)
53300	CT of the lumbar spine limited study	04.00				9.500	576.30 (505.50)
53310	CT of the lumbar spine – regional study	04.00				13.910	843.80 (740.20)
53320	Ct of the lumbar spine complete study	04.00				37.640	2283.30 (2002.90)
53330	CT of the lumbar spine pre and post contrast	04.00				58.850	3570.00 (3131.60)
53410	MR of the lumbar spine	04.00				64.320	3901.80 (3422.60)

53420	MR of the lumbar spine pre and post contrast	04.00				103.2 90	6265.80 (5496.30)
Knee							
	Codes 72140 and 72145 (patella) may not be added to 72100, 72105, 72110, 72115, 72130, 72135 (knee views) Code 72160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 72170 (introduction of contrast) may be combined with 72300 and 72305 (CT) or 72400 and 72405 (MR). The combination of 72160 (arthrography) and 72300 and 72305 (CT) or 72400 and 72405 (MR) is not supported except in exceptional circumstances with motivation.						04.00
72100	X-ray of the left knee one or two views	04.00				2.770	168.00 (147.40)
72105	X-ray of the right knee one or two views	04.00				2.770	168.00 (147.40)
72120	X-ray of the left knee including patella	04.00				4.620	280.30 (245.90)
72125	X-ray of the right knee including patella	04.00				4.620	280.30 (245.90)
Ankle and Foot							
	Code 74145 (toe) may not be combined with 74120 or 74125 (foot). Code 71450 (sesamoid bones) may be combined with 74120 or 74125 (foot) if requested. Codes 74120 and 74125 (foot) may only be combined with 74130 and 74135 (calcaneus) if specifically requested. Code 74160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 74170 (introduction of contrast) may be combined with 74300 and 74305 (CT) or 74400 and 74405 (MR). The combination of 74160 (arthrography) and 74300 and 74305 (CT) or 74400 and 74405 (MR) are not supported except in exceptional circumstances with motivation.						04.00
74100	X-ray of the left ankle	04.00				3.320	201.40 (176.70)
74105	X-ray of the right ankle	04.00				3.320	201.40 (176.70)
74120	X-ray of the left foot	04.00				2.800	169.90 (149.00)
74125	X-ray of the right foot	04.00				2.800	169.90 (149.00)
Thorax							
82600	Chest drain insertion	04.00				8.820	535.00 (469.30)
82605	Trachial, bronchial stent insertion	04.00				30.36 0	1841.70 (1615.50)
Gastrointestinal							
83600	Oesophageal stent insertion	04.00				31.22 0	1893.90 (1661.30)
83605	GIT balloon dilation	04.00				24.36 0	1477.70 (1296.20)
83615	Percutaneous gastrostomy, jejunostomy	04.00				25.36 0	1538.40 (1349.50)

SERVICES BY RADIOGRAPHERS

DIAGNOSTIC PROCEDURES

Note : Items 015, 029, 031, 033, 037, 065, 071, 073, 075, 077, 079, 081, 083, 085, 087, 089, 091, 093, 095, 097, 099, 101, 115, 117, 119, 121, 129, 131, 133, 135, 137, 139, 141, 149, 167, 171 and 173 shall only be paid on condition that the radiographer submits the name of the supervising clinician and his/her BHF practice number. The Fund shall not pay the radiographer if she/he is supervised by a radiologist.

Code	Description	Ver	Add	RVU	Fee
GENERAL RULES					
1000	When drugs, consumables and disposable items are used during a procedure, or issued to a patient on discharge, the Fund shall only reimburse the cost of such items, in line with this tariff, if the appropriate code is supplied on the account				04.00
MODIFIERS					
0001	The specified call-out fee may be charged for any bona-fide, justifiable emergency occurring at any hour which requires the practitioner to travel to the patient. The Fund may require a motivation to accompany the claim.	06.02		12.490	31.84 (27.93)
0021	Services rendered to hospital patients: Quote modifier 0021 on all accounts for services performed on hospital or day clinic patients.				04.00
0080	Multiple examinations: Full fees				04.00
0084	Films should be charged under code 300.				06.02
1	**SKELETON**				
1.1	**LIMBS**				
Code	**Description**	**Ver**	**Add**	**Radiography**	
				RVU	**Fee**
003	Limb per region, e.g. shoulder, elbow, knee, foot, hand, wrist or ankle (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	04.00		16.200	41.30 (36.20)
1.2	**SPINAL COLUMN**				
017	Per region, e.g. cervical, sacral, coccygeal, one region thoracic	04.00		24.600	62.70 (55.00)
027	Pelvis (sacro-iliac or hip joints only to be added where an extra set of views is required)	04.00		17.000	43.30 (38.00)
MYELOGRAPHY					
029	Lumbar	04.00		43.100	109.90 (96.40)
031	Thoracic	04.00		40.100	102.20 (89.60)
033	Cervical	04.00		59.400	151.40 (132.80)
035	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium)	04.00		-	-
1.3	**SKULL**				
039	Skull studies	04.00		32.300	82.30 (72.20)
043	Facial bones and/or orbits	04.00		34.900	89.00 (78.10)
045	Mandible	04.00		26.000	66.30 (58.20)
047	Nasal bone	04.00		16.200	41.30 (36.20)
049	Mastoid: Bilateral	04.00		50.000	127.50 (111.80)

CHEST						
105	Larynx (tomography included)	04.00			42.400	108.10 (94.80)
107	Chest (item 167 included)	04.00			19.200	48.90 (42.90)
109	Chest and cardiac studies (item 167 included)	04.00			23.100	58.90 (51.70)
BRONCHOGRAPHY						
115	Unilateral	04.00			33.500	85.40 (74.90)
117	Bilateral	04.00			56.500	144.00 (126.30)
119	Pleurography	04.00			15.700	40.00 (35.10)
121	Laryngography	04.00			15.700	40.00 (35.10)
123	Thoracic inlet	04.00			15.700	40.00 (35.10)
2	**ABDOMEN**					
125	Control films of the abdomen (not being part of examination for barium meal, barium enema, pyelogram, cholecystogram, cholangiogram, etc.)	04.00			17.000	43.30 (38.00)
127	Acute abdomen or equivalent studies	04.00			30.700	78.30 (68.70)
3	**GYNAECOLOGY AND OBSTETRICS**					
145	Pregnancy	04.00			19.200	48.90 (42.90)
4	**COMPUTED TOMOGRAPHY**					
155	Head, single examination, full series	04.00			262.700	669.60 (587.40)
157	Head, repeat examination at the same visit, after contrast, full series	04.00			90.200	229.90 (201.70)
159	Chest	04.00			303.700	774.10 (679.00)
161	Abdomen (including base of chest and/or pelvis)	04.00			353.000	899.80 (789.30)
MODIFIER GOVERNING THIS SPECIFIC SECTION OF THE TARIFFS						
0089	The number of sections of each examination and the matrix number must be specified. A full series of sections would be 8 or more for brain examinations, 12 or more for chest examinations and 16 or more for abdomen examinations. Fees for examinations on a matrix number of less than 250 shall be reduced by 50%	04.00				
5	**MISCELLANEOUS**					
167	Fluoroscopy: Per half hour: Add (not applicable to items 107 and 109)	04.00			21.400	54.50 (47.80)
169	Where a C-arm portable x-ray unit is used in hospital or theatre: Per half hour: Add	04.00			29.600	75.50 (66.20)
179	Attendance at operation in theatre or at radiological procedure performed by a surgeon or physician in x-ray department except 005: Per 1/2 hour: Plus fee for examination performed	04.00			17.600	44.90 (39.40)
181	Setting of sterile trays	04.00			3.000	7.65 (6.71)

	Films are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	06.02			
300	X-Ray films	06.02			
ATTENDANCE IN CATHETERISATION LABORATORY					
	Use codes 191 to 193 to charge for radiographer input where that is not included in cath lab facility fee				04.00
191	Preparation in catheterisation laboratory for purposes of cardiac catheterisation and/or invasive intravascular procedures.	04.00		43.000	109.60 (96.10)
192	Post-processing in catheterisation laboratory for purposes of cardiac catheterisation and/or invasive intravascular procedures	04.00		43.000	109.60 (96.10)
193	Coronary angiogram per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	109.60 (96.10)
215	Embolisation per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	109.60 (96.10)
RULES					
Z	No fee to be subject to more than one reduction				04.00
6	**PORTABLE UNIT EXAMINATIONS**				
185	Where portable x-ray unit is used in the hospital or theatre: Add	04.00		19.400	49.50 (43.40)
187	Theatre investigations with fixed installation : Add	04.00		8.300	21.20 (18.60)

SERVICES OF PHYSIOTHERAPISTS		
REGULATIONS DEFINING THE SCOPE OF THE PROFESSION OF PHYSIOTHERAPY (R2301 - 3 December 1976)		
SCHEDULE		
General rules governing the tariff		
002	In exceptional cases where the fee is disproportionately low in relation to the actual services rendered by the practitioner, the practitioner shall provide motivation for a higher fee and such higher fee as may be agreed upon between the practitioner and the Fund may be charged	04.00
003	Where a practitioner uses equipment which is not owned by that practitioner, a reduction of 15% of the relevant rate will be applicable. Modifier 0003 must be quoted when this rule is applied	04.00
004	In the case of prolonged or costly treatment, the practitioner should first ascertain from the Fund whether it will accept financial responsibility in respect of such treatment	04.00
005	After a series of 20 treatments in respect of one patient for the same condition, the practitioner concerned shall report to the Fund as soon as possible if further treatment is necessary. Payment for treatments in excess of the stipulated number may be granted by the Fund after receipt of a letter from the practitioner concerned, motivating the need for such treatment	04.00
006	Where emergency treatment is provided: a. during working hours, and the provision of such treatment requires the practitioner to leave her or his practice to attend to the patient in hospital; or b. after working hours the fee for such visits shall be the total fee plus 50%. For purposes of this rule: a. "emergency treatment" means a bona fide, justifiable emergency physiotherapy procedure, where failure to provide the procedure immediately would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy; and b. "working hours" means 8h00 to 17h00, Monday to Friday. Modifier 0006 must be quoted after the appropriate code number(s) to indicate that this rule is applicable.	04.00
007	Practitioners are reminded that a lower fee than that appearing in the tariff shall be charged if the customary fee in the area is less than that charged. Reduced fees shall also be charged where the practitioner would have reduced his/her fee in private practice in particular cases. Prolonged treatment or exceptional cases should also receive special consideration in accordance with the usual medical practice	04.00
008	The fee in respect of more than one procedure (excluding evaluation and visiting items 407, 501, 502, 503, 507, 509, 701, 702, 703, 704, 705, 706, 707, 708, 801, 803, 901 and 903) performed at the same consultation or visit, shall be the fee for the major procedure plus half the fee in respect of each additional procedure, but under no circumstances may fees be charged for more than three procedures carried out in the treatment of any one condition. Modifier 0008 must then be quoted after the appropriate code numbers for the additional code numbers for the additional procedures to indicate that this rule is applicable.	05.05
009	When more than one condition requires treatment and each of these conditions necessitates an individual treatment, they shall be charged as individual treatments. Full details of the nature of the treatments and the diagnosis or diagnostic codes shall be stated. Modifier 0009 must then be quoted after the appropriate code number to indicate that this rule is applicable.	04.00
010	When the treatment times of two completely separate and different conditions overlap, the fee shall be the full fee for one condition and 50% of the fee for the other condition. Both conditions must be specified. Modifier 0010 must then be quoted after the appropriate code number to indicate that this rule is applicable.	04.00

011	Every physiotherapist must acquaint himself with the provisions of the Medical Schemes Act, 1998 and the regulations promulgated under the Act in connection with the rendering of accounts. Every account shall contain the following particulars : · The name and practice code number of the referring practitioner (where applicable). · The name of the patient. · The practice code number and name of practitioner · The nature and cost of the treatment. · The date on which the service was rendered. · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	04.00
012	Where the physiotherapist performs treatment away from the treatment rooms, travelling costs being more than 16 kilometres in total) to be charged according to the AA-rate. Modifier 0013 must be quoted after the appropriate code numbers to show that this rule is applicable.	04.00
013	Physiotherapy services rendered in a nursing home or hospital. Modifier 0014 must be quoted after each code.	04.00
014	When drugs, consumables and disposable items are used during a procedure, or issued to a patient on discharge, the Fund shall only reimburse the cost of such items, in line with this tariff, if the appropriate code is supplied on the account.	04.00
Modifiers		
0001	Appointment not kept	04.00
0003	15% of the relevant rate to be deducted where equipment used is not owned by the practitioner	04.00
0006	Add 50% of the total fee for the treatment	04.00
0008	Only 50% of the fee for these additional procedures may be charged	04.00
0009	The full fee for the additional condition may be charged	04.00
0010	Only 50% of the fee for the second condition may be charged	04.00
0013	Travelling costs (being more than 16 kilometres in total) according to AA-rate.	04.00
0014	Physiotherapy services rendered to an in-patient in a nursing home or hospital.	04.00

1	**RADIATION THERAPY / MOIST HEAT / CRYOTHERAPY**				
Code	**Description**	**Ver**	**Add**	**Physiotherapy**	
				RVU	**Fee**
001	Infra-red, Radiant heat, Wax therapy Hot packs	04.00		5.000	24.10 (21.10)
005	Ultraviolet light	04.00		10.000	48.20 (42.30)
006	Laser beam	04.00		15.000	72.30 (63.40)
007	Cryotherapy	04.00		5.000	24.10 (21.10)
2	**PHYSICAL MODALITIES**				
300	Vibration	04.00		10.000	48.20 (42.30)
301	Percussion	04.00		16.100	77.60 (68.10)
302	Massage	04.00		10.000	48.20 (42.30)
307	Pre- and post-operative breathing exercises	04.00		10.000	48.20 (42.30)
318	Upper respiratory nebulisation and/or lavage	04.00		10.000	48.20 (42.30)
319	Nebulisation	04.00		10.000	48.20 (42.30)

321	Intermittent positive pressure ventilation.	04.00		10.000	48.20 (42.30)
323	Suction: Level 1 (including sputum specimen taken by suction)	04.00		5.000	24.10 (21.10)
325	Suction: Level 2 (Suction with involvement of lavage as a treatment in a special unit situation or in the respiratory compromised patient)	04.00		20.090	96.90 (85.00)
327	Bagging (used on the intubated unconscious patient or in the severely respiratory distressed patient).	04.00		5.000	24.10 (21.10)
3	**OTHER**				
117	Appointment not kept (the Fund will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the Fund" or "Patient own account" category).	04.00		-	-
937	Bird or equivalent freestanding nebuliser excluding oxygen at hospital per day.	04.00		10.000	48.20 (42.30)
939	Cost of material: Items to be charged (exclusive of VAT) at net acquisition price plus - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	04.00		-	-
940	Cost of appliances: Items to be charged (exclusive of VAT) at net acquisition price plus- 26% of the net acquisition price where the net acquisition price of that appliance is less than one hundred rands; a maximum of twenty six rands where the net acquisition price of that appliance is greater than or equal to one hundred rands.	04.00		-	-
941	Hiring equipment: 1% of the current replacement value of the equipment per day. Total charge not to exceed 50% of replacement value. Description of equipment to be supplied.	04.00			
	Payment of this item is at the discretion of the Fund, and should be considered in instances where cost savings can be achieved. By prior arrangement with the Fund	05.03			

SERVICES BY OCCUPATIONAL AND ART THERAPISTS		
REGULATIONS DEFINING THE SCOPE OF THE PROFESSION OF OCCUPATIONAL THERAPY (R2145 - 31 July 1992)		
GENERAL RULES		
006	Where emergency treatment is provided: a. during working hours, and the provision of such treatment requires the practitioner to leave her or his practice to attend to the patient in hospital; or b. after working hours the fee for such visits shall be the total fee plus 50%. For purposes of this rule: a. "emergency treatment" means a bona fide, justifiable emergency occupational therapy procedure, where failure to provide the procedure immediately would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy; and b. "working hours" means 8h00 to 17h00, Monday to Friday. Modifier 0006 must be quoted after the appropriate code number(s) to indicate that this rule is applicable. Rule 006 does not apply to art therapy.	05.02
008	The provision of assistive devices shall be charged (exclusive of VAT) at net acquisition price plus – - 26% of the net acquisition price where the net acquisition price of that appliance is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that appliance is greater than or equal to one hundred rands. Modifier 0008 must be quoted after the appropriate code numbers to show that this rule is applicable.	04.00
009	Materials used in the construction of orthoses or pressure garments shall be charged (exclusive of VAT) at net acquisition price plus - - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands. Modifier 0009 must be quoted after the appropriate code numbers to show that this rule is applicable. Rule 009 does not apply to art therapy.	04.00
010	Materials used in treatment shall be charged (exclusive of VAT) at net acquisition price plus - - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands. Modifier 0010 must be quoted after the appropriate code numbers to show that this rule is applicable.	04.00
011	Where the therapist performs treatments away from the treatment rooms, travelling costs to be charged according to AA rates e.g. for domicilliary treatments or treatments in nursing homes. Modifier 0011 must be quoted after the appropriate code numbers to show that this rule is applicable.	04.00

012	Every practitioner shall render a monthly account in respect of any service rendered during the month, irrespective of whether or not the treatment has been completed. NB. Every account shall contain the following particulars: i The name and practice number of the consulting occupational or art therapist. ii The name of the patient/ claimant. iii The reference number of the patient/ claimant. iv The nature of the treatment. v The date on which the service was rendered. vi The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	05.02
013	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge shall only be reimbursed by the Fund if the appropriate code is supplied on the account. Please note: In the case of occupational therapy, a code will only be required when a standard proprietary (off the shelf) product is used. When a splint or support is made by the occupational therapist using or modifying one or more components, a code cannot accurately identify this non-standard product. Please refer to annexure itemising the most commonly made non-standard products used in occupational therapy and bill accordingly. The Occupational Therapy Association of S A has made available a generic list of non-proprietary splints and pressure garments commonly made by practitioners. The type of materials used to manufacture these products is at the discretion of the practitioner concerned. Price of splints and pressure garments may vary. See Annexures A & B.	04.00
Modifiers		
0006	Add 50% of the total fee for the procedure. Modifier 0006 does not apply to art therapy.	04.00
0008	Assistive devices to be charged (exclusive of VAT) at net acquisition price plus – - 26% of the net acquisition price where the net acquisition price of that appliance is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that appliance is greater than or equal to one hundred rands.	04.00
0009	Materials used for orthoses or pressure garments to be charged (exclusive of VAT) at net acquisition price plus - - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands. See Annexures A & B for non-standard products. Modifier 0009 does not apply to art therapy.	05.02
0010	Materials used in treatment to be charged (exclusive of VAT) at net acquisition price plus - - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	04.00
0011	Travelling costs according to AA rates.	04.00

Code	Description	Ver	Add	Occupational Therapy		Arts Therapy	
				RVU	Fee	RVU	Fee
0021	Services rendered to hospital inpatients: Quote modifier 0021 on all accounts for services performed on hospital inpatients.				04.00		
ITEMS							
1	**PROCEDURES OF INTERVIEWING, GUIDANCE AND CONSULTANCY**						
108	Interview, guidance or consultation: 30 minute duration.	06.02		21.250	107.60 (94.40)	21.250	58.90 (51.70)
109	Interview, guidance or consultation. Each additional 15 mins. A maximum of four instances of this code may be charged per session.	06.02	+	10.630	53.80 (47.20)	10.625	29.40 (25.80)
	Time based items in this section exclude time spent on procedures charged in addition to the consultation	05.02					
107	Appointment not kept (fund will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the fund" or "Patient own account" category).	04.00		-	-	-	-
110	Reports. To be used to motivate for therapy and/or give a progress report and/or a pre-authorisation report, where such a report is specifically required by the Fund.	05.02		16.500	83.50 (73.20)	22.140	61.30 (53.80)
2	**PROCEDURES OF INITIAL EVALUATION TO DETERMINE THE TREATMENT.**						
215	A dynamic orthosis.	04.00		7.500	38.00 (33.30)		
217	A pressure garment for one limb.	04.00		7.500	38.00 (33.30)		
221	A pressure garment for the trunk.	04.00		7.500	38.00 (33.30)		
3 List of splints and pressure garments exempted from NAPPI codes							
Annexure A							
	Numbers and names of splints to be used with modifier 0009						04.00
701	Static finger extension/flexion splint	04.11		-	-		
702	Dynamic finger extension/flexion	04.11		-	-		
706	Hand based static finger extension/flexion	04.00		-	-		
707	Hand based static thumb extension/flexion/opposition/ abduction	04.00		-	-		
708	Hand based dynamic finger flexion/extension	04.00		-	-		
709	Hand based dynamic thumb flexion/extension/opposition/abduction	04.00		-	-		
710	Static wrist extension/flexion	04.00		-	-		
711	Dynamic wrist extension/flexion	04.00		-	-		
713	Forearm based dynamic finger flexion/extension	04.00		-	-		
714	Forearm based dorsal protection	04.00		-	-		
715	Forearm based volar resting	04.00		-	-		
716	Static elbow extension/flexion	04.00		-	-		
717	Dynamic elbow flexion/extension splint	04.00		-	-		

718	Shoulder abduction splint	04.00		-	-		
719	Static rigid neck splint	04.00		-	-		
720	Static soft neck splint/brace	04.00		-	-		
721	Static knee extension	04.00		-	-		
722	Static foot dorsiflexion	04.00		-	-		
Annexure B							
	Numbers and names of pressure garments to be used with modifier 0009						04.00
801	Glove to wrist	04.00		-	-		
802	Glove to elbow	04.00		-	-		
803	Gauntlet (Glove with palm and thumb only)	04.00		-	-		
804	Sleeve: Upper/forearm	04.00		-	-		
805	Sleeve: full	04.00		-	-		
806	Vest + sleeves	04.00		-	-		

SERVICES BY CLINICAL TECHNOLOGISTS					
GENERAL RULES					
001	When drugs, consumables and disposable items are used during a procedure, or issued to a patient on discharge, the Fund shall only reimburse the cost of such items, in line with this tariff, if the appropriate code is supplied on the account.				04.00
MODIFIERS					
0001	Fee prorated according to number of treatment days;. fee = ([number of treatment days] / 30) X (item fee)				05.03
ITEMS					
Surgical Support					
Code	**Description**	**Ver**	**Add**	**Clinical Technology**	
				RVU	**Fee**
010	Ablations	04.00		219.700	1508.00 (1322.80)
011	Preparation of extra-corporeal equipment for surgical procedures.	04.00		196.700	1350.10 (1184.30)
012	Operation of heart laser during myocardial revascularisation	04.00		219.700	1508.00 (1322.80)
013	Continued operation of extra-corporeal equipment during surgery for a time in excess of one hour in 30 minute increments or part thereof provided that such part comprises 50% or more of the time	04.00		20.300	139.30 (122.20)
014	Radiofrequency Catheter Ablations	04.00		219.700	1508.00 (1322.80)

	Not to be charged with item 012	05.03			
015	Preparation and operation of pre-operative, intra-operative or post operative physiological monitoring per patient, per admission	04.00		19.400	133.20 (116.80)
	May only submit once in theatre and once in catheterisation laboratory	05.03			
017	Standby with extra-corporeal equipment for surgery within hospital	04.00		58.800	403.60 (354.00)
	Cannot be used with 011	05.03			
019	Standby within the hospital for coronary angioplasty.	04.00		19.400	133.20 (116.80)
021	Preparation and operation of intra-aortic balloon pump in theatre, intensive care unit and catheterisation laboratory.	04.00		58.800	403.60 (354.00)
085	Each additional 30 minutes or part thereof, provided that such part comprises 50% or more of the time.	04.00		10.000	68.60 (60.20)
023	Global fee for preparation and operation and removal of cardio assist device (LVAD, RVAD, BVAD) in theatre and intensive care unit.	04.00		196.700	1350.10 (1184.30)
027	Preparation and operation of a pre- and post-operative blood salvage device.	04.00		19.400	133.20 (116.80)
029	Preparation and operation of an autotransfusion cell washing system.	04.00		77.100	529.20 (464.20)
031	Determination and monitoring of haemodynamic/pulmonary parameters, metabolism, arterial/venous pressure flow studies in high care/ICU (per patient per multiple procedures per day)	04.00		61.700	423.50 (371.50)
033	Assistance with bronchoscopy procedures, placement of arterial/venous catheters, ultrasound examinations or photography.	04.00		14.600	100.20 (87.90)
034	Lymph compression treatment.	04.00		22.500	154.40 (135.40)
116	Preparation and operation of an artificial heart (Berlin-Heart)	04.00		219.700	1508.00 (1322.80)
118	Daily monitoring of artificial heart, per hour	04.00		33.400	229.30 (201.10)
157	Standby with extra corporeal equipment (maximum 4 hours) (per event).	04.00		26.300	180.50 (158.30)
Pulmonology					
	Items 035 to 061 apply only to outpatient department and normal wards - Not high care or intensive care, except item 050 which applies to intensive care only.				04.00
035	Nebulization (per one procedure).	04.00		12.300	84.40 (74.00)
037	Measurement of Lung volumes and capacities by means of closed circuit (He) or (N2) washout or body plethysmography.	04.00		24.200	166.10 (145.70)

039	Flow-volume determinations.	04.00		30.600	210.00 (184.20)
041	Flow-volume (Pre-post B-D).	04.00		50.800	348.70 (305.90)
043	Airways resistance and conductance measurements using plethysmograph or similar apparatus.	04.00		24.200	166.10 (145.70)
045	Gas distribution measurements.	04.00		24.200	166.10 (145.70)
047	Diffusion determinations.	04.00		24.200	166.10 (145.70)
050	ECMO change-out and re-establishment.	04.00		46.300	317.80 (278.80)
Cardiology					
062	Assist in preparations and operations of Rotablator Procedures	04.00		29.900	205.20 (180.00)
063	Cardiac catheterisation for the first hour.	04.00		40.300	276.60 (242.60)
065	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		10.000	68.60 (60.20)
064	Intravascular Ultrasound (IVUS)	04.00		25.700	176.40 (154.70)
	This fee can only be charged once, irrespective of how many times this procedure is repeated. The technologist cannot charge for this procedure if a representative of a company or any other person is operating the IVUS machine	05.03			
068	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time.	04.00		10.000	68.60 (60.20)
066	Cardiac Cath Right Heart Studies	04.00		56.000	384.40 (337.20)
067	Cardiac Electro physiology and related procedures for first FOUR hours.	04.00		67.900	466.10 (408.90)
Dialysis					
145	Preparation of extra-corporeal equipment: Haemoperfusion (HP), Haemofiltration (HF), Haemoconcentration (HC), Continuous renal replacement therapy (CRRT), Aphaeresis, Auto transfusion and cell recovery (AT).	04.00		46.300	317.80 (278.80)
147	Peritoneal dialysis, per day	04.00		16.800	115.30 (101.10)

	The global fees for Continuous Ambulatory Peritoneal Dialysis (CAPD) (Item 176) and Automated Peritoneal Dialysis (APD) (Item 177) include: consumables; cost of machine and machine disposables; professional fee; initial training; in-centre follow-up visits; and home visits. However, they exclude Tenckhoff catheter and insertion thereof; and disposables required for a transfer set change (usually 6 monthly). These fees are chargeable for each 30 day cycle in which CAPD or APD is provided. If CAPD or APD is provided for less than a 30 days in any one cycle (for example due to complications or death of the patient): a. if the period of treatment is 26 days or more in that cycle, the full fee applies; b. if the period of treatment is up to 25 days in that cycle, the fee should be prorated according to number of actual treatment days. Modifier 0001 should be quoted, and number of treatment days specified.	05.03			
151	Treatment procedures for CRRT up to 6 hours or part thereof provided that such part comprises 50% or more of the time	04.00		24.800	170.20 (149.30)
152	Treatment procedure for CRRT up to 12 hours or part thereof provided that such part comprises more than 6 hours of the time	04.00		49.700	341.10 (299.20)
154	Treatment procedure for CRRT up to 18 hours or part thereof provided that such part comprises more than 12 hours of the time	04.00		74.500	511.40 (448.60)
156	Treatment procedure for CRRT up to 24 hours or part thereof provided that such part comprises more than 18 hours of the time	04.00		99.300	681.60 (597.90)
Miscellaneous					
171	Travelling per km in excess of 16km (in own car).	04.00		0.675	4.63 (4.06)
173	Equipment hire (By arrangement with the Fund).	04.00		-	-
175	Medication / Material	04.00		-	-
	The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	05.03			

ANNEXURE B

FORMS

RAF 1

CLAIM FOR COMPENSATION AND MEDICAL REPORT

(SECTIONS 17(1) AND 24(1)(*a*) OF ACT NO. 56 OF 1996 AND REGULATION 9(1) OF THE REGULATIONS UNDER THE ACT)

1) A separate form must be completed and lodged with regard to each injured or deceased person in respect of whose bodily injury or death compensation is claimed.

2) In order for the Fund to be able to deal with this claim expeditiously it is essential that all the required supporting vouchers and statements should accompany this form and in the case of item 6 of this form it is desirable also to-
(a) attach all medico-legal reports in the possession of the claimant; and
(b) indicate, with regard to a claim for future loss of earnings, on a separate statement how such loss is calculated.

3) Written authority for inspection by or on behalf of the Fund of all records regarding the injured or deceased person which may be in the possession of any hospital or medical practitioner must accompany this form.

4) Items 1 to 4 of this form must be completed before this form is submitted to the medical practitioner for completion of the medical report.

5) The liability of the Fund to pay hospital, medical and related expenses is limited to one of two tariffs, the one tariff being applicable in cases of emergency medical treatment and the other being the UPFS, as provided for under regulation 5 of the Regulations under the Act.

6) The liability of the Fund for non-pecuniary loss is limited to injuries which after assessment, in accordance with the method prescribed under regulation 3 of the Regulations under the Act, are assessed to be serious.

7) If required, please contact the Fund to assist you with the completion of the form and with the lodgment of your claim directly with the Fund.

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1. PARTICULARS OF THE CLAIMANT

Name(s)	
Surname	
ID Number / Passport Number	
Citizenship	
Telephone number / Cell number	
Facsimile number	
E-mail address	
Physical address	
Postal address	
Capacity in which claiming (i.e. self, guardian, *curator ad litem*)	
Banking details for purposes of payment by the Road Accident Fund	
Name and surname of account holder	
Bank name	
Branch name	
Bank account number	
Branch code	
Account type	

2. PARTICULARS OF THE MOTOR VEHICLE FROM THE DRIVING OF WHICH THIS CLAIM ARISES

Registration number	
Particulars of the driver of the motor vehicle	
Name(s) and surname	
Physical address	

Postal address	
Telephone number / Cell number	
Particulars of the owner of the motor vehicle, where the owner was not the driver	
Name(s) and surname	
Physical address	
Postal address	
Telephone number / Cell number	
NOTE: If the identity of neither the owner nor the driver has been established, attach a separate statement stating any additional information regarding the vehicle and describe what steps were taken to establish the identity of the owner or driver of the vehicle.	

3. **PARTICULARS OF THE ACCIDENT**

What was the date of the accident?	
What was the time of the accident?	
Where did the accident take place?	
At which police station was the accident reported?	
What is the police reference number?	
State whether the injured / deceased was a driver, passenger, cyclist or pedestrian -	
Where applicable, state the registration number of the vehicle of which the injured / deceased was the driver; alternatively on, or in, which the injured / deceased was a passenger -	
NOTE: Attach an affidavit (supported by a rough sketch of the scene of the accident) in which particulars of the accident are fully set out, and attach copies of all available statements (including eyewitness accounts) and related documents (including the police accident report and plan).	
Particulars of any other motor vehicles involved in the accident -	
Registration number	
Name(s) and surname of driver	
Physical address	
Postal address	
Telephone number / Cell number	
NOTE: If more than two vehicles were involved in the accident set out the above particulars of the other vehicles involved in an annexure to this claim form.	

4. **PARTICULARS OF THE INJURED OR DECEASED**

NOTE: Where the claimant is also the injured the particulars required hereunder *need not be* furnished again – in all other instances the particulars *must* be furnished.	
Name(s)	
Surname	
ID Number / Passport Number	
Citizenship	
Telephone number / Cell number	
Facsimile number	
E-mail address	
Physical address	
Postal address	
NOTE: The particulars hereunder *must* be furnished in all instances, including instances where the claimant is also the injured.	
Marital status (i.e. married, divorced, single, etc.)	
Business or occupation	
Name of employer	
Postal address of employer	
Telephone / Cell number of employer	

Facsimile number of employer	
State the income of the injured / deceased for the 12 months immediately preceding the accident	R
Was the injured or deceased injured in the course of his / her employment?	
Where the injured is entitled to, or has received, compensation under the Compensation for Occupational Injuries Act, 1993, state-	
The Compensation Commissioner's reference number, if known	
What amount has been received	R

5. **PARTICULARS OF DEPENDANTS WHERE LOSS OF SUPPORT IS CLAIMED**

NOTE: Where the claimant is also a dependant the particulars required hereunder *need not be* furnished again – in respect of the other dependants the particulars *must* be furnished.	
Name(s)	
Surname	
ID Number / Passport Number	
Citizenship	
Telephone number / Cell number	
Facsimile number	
E-mail address	
Physical address	
Postal address	
NOTE: The particulars hereunder *must* be furnished in all instances, including instances where the claimant is also a dependant.	
Relationship to deceased (i.e. wife, son, daughter, etc.)	
Marital status (i.e. married, divorced, single, etc.)	
Business or occupation	
Name of employer	
Postal address of employer	
Telephone number of employer	
Facsimile number of employer	
Income for 12 months immediately preceding the accident	R
Where the deceased's dependant(s) are entitled to, or have received ,compensation under the Compensation for Occupational Injuries Act, 1993, state-	
The Compensation Commissioner's reference number	
What amount has been received	R

6. **PARTICULARS OF THE COMPENSATION CLAIMED**

Hospital expenses	R
Medical expenses	R
Estimated future medical expenses	R
Past loss of income	R
Future loss of income	R
Past loss of support	R
Future loss of support	R
Funeral expenses	R
Non-pecuniary loss	R
Total amount claimed	R

7. **DECLARATION**

I hereby declare that to the best of my knowledge and belief the information set out in this form is true and correct in every respect.	
Signature of claimant, as per item 1 above (alternatively the signature of the claimant's authorised legal representative, in which case a written special power of attorney must accompany this claim form)	.... Signature of claimant / legal representative
Signature of witness	.... Witness
Signature of witness	.... Witness

Signed at	....
Date	....

MEDICAL REPORT

1) Section 24(2)(*a*) provides that this report shall be completed by the medical practitioner who treated the injured or deceased person for the bodily injuries sustained by him/her in the accident from which this claim arises or by the superintendent (or his/her representative) of the hospital in which the injured or deceased person was treated for such bodily injuries.

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1. DETAILS OF PATIENT

Name(s)	
Surname	
ID number / passport number / date of birth	
Are you satisfied that the patient is the person mentioned under item 4 (four) of the claim form?	

2. PATIENT'S MEDICAL HISTORY AND PROGNOSIS

Date when first seen after the accident	
Did you treat the patient at any time before the accident? If so, state the date of the last treatment and the nature of the ailment -	

Indicate, with a "X", which body part(s) sustained an injury(ies) and the degree of such injury(ies), also state the applicable ICD Code(s)-

Body Part	Head	Chest	Neck	Abdomen	Back	Upper Limbs	Lower Limbs	Pelvis
ICD - 10 Code(s)								

State full details of the nature of the injuries and any complications (e.g. fractured ribs with haemothorax, compound fracture left tibia, disfigurement, etc.) and state treatment given-

Has the patient's condition stabilized? If not, furnish details -	
Is any permanent disability expected? If so, furnish details -	
Is specialist treatment being given? If so, state the name and address of the specialist, where such treatment is being given -	
If the patient is employed state when return to employment is expected -	
Where future medical treatment is foreseen, state -	
In respect of which injuries	
Probable nature of treatment	
Expected duration of treatment	
Estimated cost of treatment	R
If hospitalisation is foreseen	
Expected date of such hospitalization, if foreseen	
Expected duration of hospitalisation, if foreseen	

Has the injury(ies) aggravated any pre-existing pathological condition or has any such pre-existing condition aggravated the effects of trauma (furnish full details)-

Where the patient has been confined to a hospital / nursing home or other facility state -	
Name and address of the institution	
Patient's hospital / other reference number	
Date discharged / discharge expected	
In the case where the patient died state -	
Date of death	
Whether any pre-existing pathological condition contributed to the death? Furnish full details where applicable -	

3. **MEDICAL PRACTITIONER'S DETAILS**

Name	
Surname	
Qualifications	
Practice Number (HPCSA and/or BHF)	
Telephone number	
Facsimile number	
E-mail address	
Cell number	
Physical address	
Postal address	

4. **DECLARATION**

I hereby declare that to the best of my knowledge and belief the information set out in this form is true and correct in every respect.	
Signature of medical practitioner who's details are furnished in item 3 above and who completed this medical report	....
Signed at	....
Date	....

RAF 3

ACCIDENT REPORT FORM

(SECTION 22(1)(a) OF ACT NO. 56 OF 1996 AND REGULATION 9(3) OF THE REGULATIONS UNDER THE ACT)

1) When any person has been injured or killed as a result of the driving of a motor vehicle, the owner and the driver of that motor vehicle must report that accident to the Fund on this form within 14 days, failing which the compensation paid to the third party may be recovered from that owner or driver.

Postage will be paid by the Addressee

No postage necessary if posted in the Republic of South Africa

CHIEF EXECUTIVE OFFICER
P O Box 2743
PRETORIA
0001

1. PARTICULARS OF THE *DRIVER* OF THE VEHICLE

Name(s)	
Surname	
ID Number / Passport Number	
Citizenship	
Telephone number	
Facsimile number	
Cell number	
E-mail address	
Physical address	
Postal address	
Driver's License Number	
Date issued	
Endorsements, if any	
Physical / mental defects, if any	
State whether you are also the owner of the vehicle -	

2. **PARTICULARS OF THE *OWNER* OF THE VEHICLE - COMPLETE WHERE THE DRIVER WAS NOT THE OWNER**

Name(s)	
Surname	
ID Number / Passport Number	
Citizenship	
Telephone number	
Facsimile number	
Cell number	
E-mail address	
Physical address	
Postal address	

3. **PARTICULARS OF THE *MOTOR VEHICLE***

Registration number	
Body (i.e. sedan, truck, bus etc.)	
Color	
Make	
Model	
Year	

4. **PARTICULARS OF *OTHER MOTOR VEHICLES* INVOLVED IN THE ACCIDENT**

Motor Vehicle	Vehicle 1	Vehicle 2	Vehicle 3
Registration number			
Name(s) and surname of driver			
Physical address			
Postal address			
Telephone number / Cell number			
Name(s) and surname of owner			
Physical address			
Postal address			
Telephone number / Cell number			
NOTE: If more vehicles were involved in the accident set out the above particulars of the other vehicles involved in an annexure to this claim form.			

5. **PARTICULARS OF *THE ACCIDENT***

What was the date of the accident?	
What was the time of the accident?	
Where did the accident take place?	
At which police station was the accident reported?	
What is the police reference number?	

6. **PARTICULARS OF *WITNESS(ES)* TO THE ACCIDENT**

Witness	Witness 1	Witness 2	Witness 3
Name(s)			
Surname			
ID Number / Passport Number			
Telephone number			
Facsimile number			
Cell number			
E-mail address			

Physical address			
Postal address			

7. PARTICULARS OF PERSON(S) INJURED / DECEASED

Persons injured / deceased	Person 1	Person 2	Person 3
Name(s)			
Surname			
ID Number / Passport Number			
Telephone number			
Facsimile number			
Cell number			
E-mail address			
Physical address			
Postal address			
State whether the injured / deceased was a driver, passenger, cyclist or pedestrian -			
Where applicable, state the registration number of the vehicle of which the injured / deceased was the driver; alternatively on, or in, which the injured / deceased was a passenger -			

8. CONDITIONS AT THE TIME OF THE ACCIDENT

Time of day (i.e. dawn, day, dusk, night)	
Weather conditions (i.e. sunny, misty, cloudy, raining, etc.)	
Visibility (i.e. good, reasonable, bad, etc.)	
Road surface (i.e. gravel, sand, tar, etc.)	
Street lights - on or off	
Own vehicle's lights – off, dim, bright	
Other vehicle's lights – off, dim , bright	
Speed of own vehicle at time of accident	

9. SKETCH PLAN OF THE SCENE OF THE ACCIDENT

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9. DETAILED DESCRIPTION OF THE ACCIDENT

10. DECLARATION

I / we hereby declare that to the best of my / our knowledge and belief the information set out in this form is true and correct in every respect.	
Signature of driver	…………………………………………………………………………… Signature of driver
Signature of owner	…………………………………………………………………………… Signature of owner (if not also the driver).
Signed at	……………………………………………………………………………
Date	……………………………………………………………………………

IMPORTANT NOTICE

GPW wishes to apologise for any confusion created by our previous notice concerning the method of payment *(herewith the corrected version of the notice):*

ACCEPTABLE PAYMENT FOR SERVICES AND GOODS IN GOVERNMENT PRINTING WORKS

WITH IMMEDIATE EFFECT ALL PAYMENTS FOR SERVICES RENDERED AND GOODS DISPATCHED SHOULD BE BY MEANS OF CASH, ELECTRONIC TRANSFER OR BANK GUARANTEED CHEQUES

IMPLEMENTATION OF THIS CIRCULAR IS WITHOUT EXCEPTION

S. MBHELE
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