Format
SwitchClaim

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Contents

SwitchOn SwitchClaim Message Format

Message Transaction Type

Transaction Type	Description

Message Requirements

- Files are ASCII text files.
- The pipe symbol (|) is used as a trailing field terminator within the record types (not in the file header). The last field in each record type should still have its field terminator.
- Each record type should be CR/LF terminated in a Windows/DOS environment, or LF terminated in a UNIX environment.
- options for Doctors (G), Dentist (D), Pharmacy (P), Opticians (O) and Hospital (H) or ALL, where all suppliers must populate fields with data.
- The minimal mandatory fields required to constitute a transaction have been specified under the **if submitted** (although not marked as mandatory) and guaranteed to be returned with the response files Although submitting only the minimum dataset will constitute a legitimate transaction, the PMA should populate all fields as far as possible to ensure that the claims is processed without delay by the Medical Scheme / Administrator.
- Certain destinations and funders are unable to process claims containing special characters. The PMA should therefore proactively discourage the use of special characters when users capture patient and claim data as well as when the electronic message is being created.
- As the medical scheme requirements change, additional fields may be added to the record definition from time to time. It is important that the SERVICE PROVIDER SOFTWARE is written defensively since MediSwitch reserves the right to add to the number of fields in any Layout or to populate fields 'reserved for future use' at any time. Do NOT zero fill fields, unless specified in this document.
- For every type of transaction the following structure will apply: The { } bracket construct represents repetitive sections/records, whilst the [ ] bracket construct represents optional sections/records.

LEGEND:

Message Record Types

The following record types have been defined to allow the same message structure to be used by any Service Provider wishing to send transactions via the VPHN:

RECORD TYPE	DEFINITION
H	Header Record
S	Record showing information regarding the Service Provider who is submitting the claim
M	Record showing membership information.
P	Record showing patient information.
HA	Record showing admission date/time into hospital.
HD	Record showing date/ time of discharge from hospital.
DR	Record showing detailed doctor information. There can be multiple doctor detail records per patient (claim) record and / or per treatment record. Note that for an Admitting, Referring, Referred To or Discharging DR records (field DR4 = 04, 05, 06 or 07) the DR record should be on claim level. For Attending/Treating/Prescribing, Assisting and Anaesthetist DR records (field DR4 = 01, 02 and 03) the DR record should be on treatment level.
D	Record showing diagnostic information per doctor type. There may be multiple diagnoses for multiple doctor types per treatment record The D record may follow the P record (for claim level diagnoses eg referring doctor diagnoses) or the T, C and L records (for treatment / claim line level diagnoses eg attending / treating doctor diagnoses) Note that for an Admitting, referring or discharging D records (field D2 = 02, 03 or 04) the D record should be on claim level. For Attending or Prescribing D records (field D2 = 01) the D record should be on treatment or line level. If an Attending D record (field D2 = 01) applies to all the treatment lines of a treatment, the D record should only be supplied on the header level. If however the D records differ per line of a treatment, it should be supplied on each individual line
T	Record showing treatment information. treatments include any consultation or procedure (tariff code), materials / consumables used during a consultation or procedure and the prescription for any medicines that were prescribed (the details related to the medicines prescribed are populated in the C record).
PR	The procedure record can be repeated per tariff treatment e.g. for different procedures performed whilst patient is in theatre. For hospital claims, the PR record must also be included at header level to indicate the Planned Tariff/Procedure codes at the time of admission this may/may not be the procedure eventually performed, depending on the diagnosis made in hospital

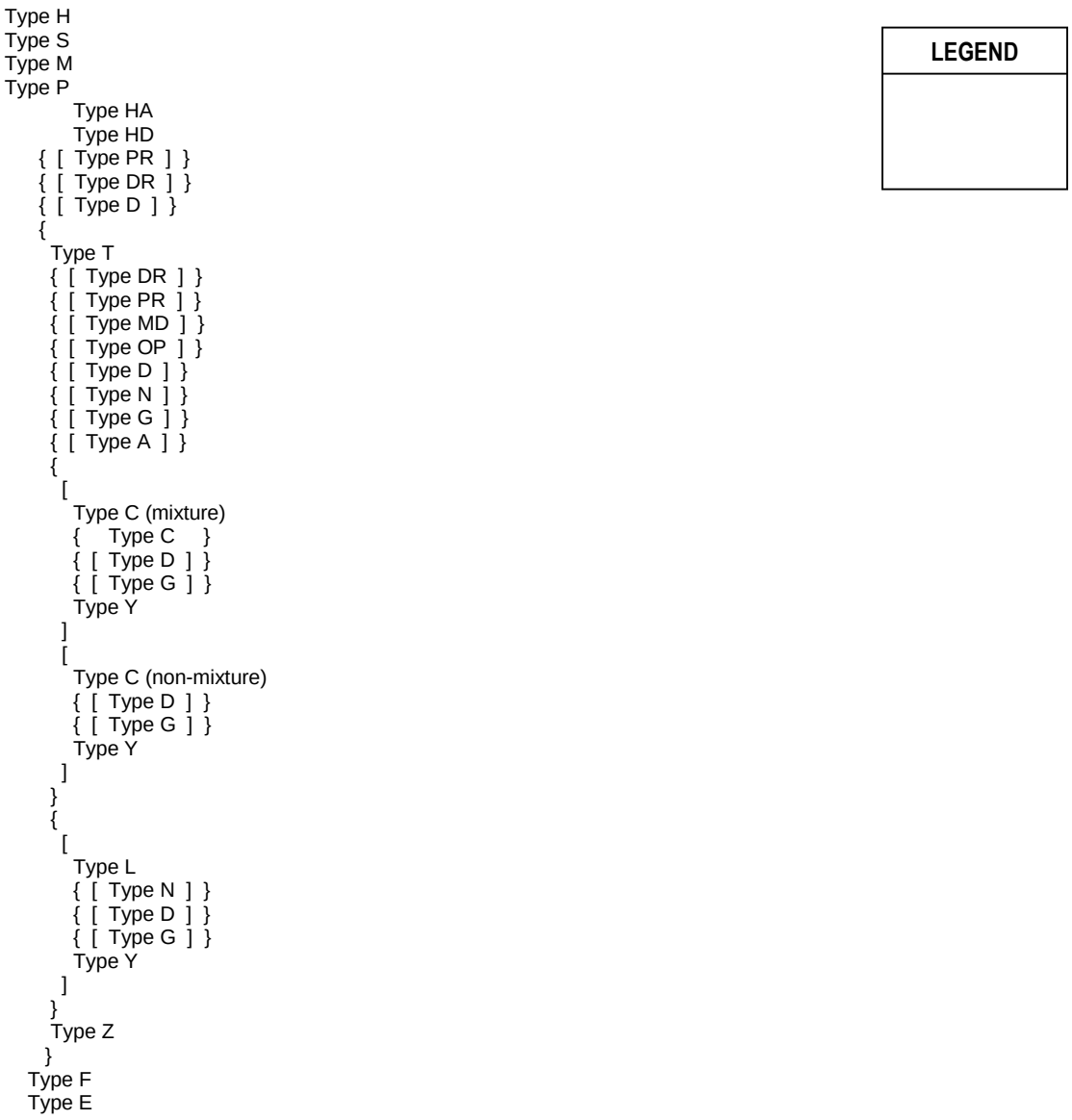
RECORD TYPE	DEFINITION
MD	Record showing modifier information. This record is used for tariffs / treatments that include modifiers that are billed on the same line as the tariff with a single value. T12 is used to submit the tariff and the MD record is used to submit the accompanying modifier codes There may therefore be multiple modifier codes per treatment.
OP	Record showing optometry prescription detail. There can be multiple optometry detail records per tariff item. Lens prescriptions are specified per eye.
N	Record
G	Record showing additional general comments. This record type may appear in a number of different positions within the claim depending on the information being passed.
A	Record indicating the filename of an attachment. The attachment is not sent as part of the claim but separately this is a reference to that attachment. Method of delivery of these files still has to be finalized.
C	Record showing consumable/medicine information. This is a conditional record that need only be written out if the preceding treatment type each medicine prescribed.
L	Record showing dental lab information detail. There can be multiple dental lab claims associated with the dentist claim. Tariff code
Y	Record showing monetary information ie item line totals
Z	Record showing monetary information i.e. treatment / prescription totals.
F	Record showing footer information i.e. claim totals.
E	Record type indicating the end of a file.
R	Record showing Claim response codes and messages There may be multiple R records.
U	Record showing Drug Utilization Review (DUR) information. This information will not always be available depending on the system used by the Medical Fund.
RV	Record showing MSV response codes and messages

RECORD TYPE	DEFINITION
EB	Record showing eRA bank deposit details
I	Record showing claim item details for eRA responses
EY	Record showing claim item financial details for eRA responses
EA	Record showing item financial allocation details for eRA responses
EJ	Record showing journal details for eRA responses
DS	Record showing disclaimer information for eRA responses
AF	Record showing additional financial information details for eRA responses
EZ	Record showing member total record details for eRA responses
EF	Record showing eRA financial totals record
DC	Record showing destination code file details

- Note that all monetary values must be VAT inclusive

SwitchClaim Request and Response Format

Request Message Structure



Request Message Records

Header (Start of Message) Record Type aHb

Header (Start of Message) Record Type aHb SwitchClaim Request Format					
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..1	ALL	M	"H"
2	Transmission Number	I..10	ALL	M R	Unique sequential number generated by the PMA to identify this claim or batch of claims. This number is also used to populate E2 of the request message Returned in H2 and E2 of the response message
3	SwitchClaim Version number	N..10	ALL	M	The version no of the SwitchClaim Format
4	PMA Software Package and Version No	An..30	ALL	M	The PMA software package and version number via which the claim is submitted. The version number should be separated from the package name using a colon (:)
5	eRA Version Number	N..10	All	M	The version no of the eRA format that must be returned.

Service Provider Record a b

Service Provider Record Type aSb SwitchClaim Request Format					
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..1	ALL	M	
2	Request File Creation Date/Time	Dt..12	ALL	M	Date/Time stamp the request file is created (CCYYMMDDhhmm).
3	Billing Practice PCNS number	An..18	ALL	M R	PCNS number of Billing Practice Returned in S3 of the response message
4	Billing Practice Name	An..40	ALL		Name of Billing Practice

Service Provider Record Type a5b					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
5	PMA Dataset Identifier	An..50	ALL	CM R	The PMA dataset from which the claim originated. This field is mandatory if the Service Provider / Billing practice has multiple datasets. This field is used by the PMA to link back responses to their corresponding datasets. Returned in S5 of the response message
6	/ Billing Practice VAT Registration number	An..15	ALL	CM	The VAT registration number of the Service Provider / Billing Practice. Mandatory if the practice is registered for VAT.

Member Record a b

Member Record a b					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..1	ALL	M	
2	Member ID	An..20	ALL		ID / Passport number of the principal member
3	Member Title	An..5	ALL		Title of the principal member e.g. Mr, Dr.
4	Member Initials	An..10	ALL		Initial(s) of the principal member.
5	Member Surname	An..30	ALL	M R	Surname of the principal member. Returned in M2 of the response message
6	Member Full Names	An..30	ALL	M R	Full name(s) of the principal member. Returned in M3 of the response message
7	Membership Number	An..20	ALL	CM R	Medical Fund membership number of the principal member. Mandatory for transaction types 302, 303 and 304 Returned in M4 of the response message
8	Card Swipe Indicator	An..1	ALL		Y/N Indicator to show if the member information was retrieved by swiping a membership card.
9	Account No	An..15	ALL	M R	Member's account number in the Service Provider's PMA Returned in M5 of the response message
10	Address 1	An..35	ALL		Postal Address Line 1

Member Record a b					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
11	Address 2	An..35	ALL		Postal Address Line 2
12	Town/City	An..35	ALL		Town/City
13	Postal Code	An..4	ALL		Postal Code
14	Cardholder Telephone / Cellphone No	An..20	ALL		Telephone / Cellphone number of the principal member
15	Medical Scheme Plan / Option Name	An..20	ALL		The plan / option name of the medical scheme
16	Medical Scheme Plan / Option Reference / Number	An..14	ALL		The plan / option number of the medical scheme.
17	Medical Scheme Name	An..20	ALL		The name of the medical scheme
18	Medical Scheme Registration Number	An..15	ALL		Registration number of Medical Scheme
19	Medical Scheme Registration Type indicator	An..2	ALL		01 CMS Registration Number 02 Phisc Registration Number 03 Other
20	Medical Scheme Claim option	AN..15	ALL		Medical Scheme claiming arrangements specific to this claim ie contract / network / re-imbursement arrangement
21	SwitchOn Destination Code	An..8	ALL	M	SwitchOn Destination Code for the Medical Scheme / Plan

Patient Record a b

Patient Record Type a b					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..1	ALL	M	
2	Dependant Code	An..3	ALL	R	by the Medical Fund (scheme specific) Returned in P2 of the response message
3	Patient Surname	An..30	ALL	M R	Surname of the person receiving treatment Returned in P3 of the response message
4	Patient Initials	An..5	ALL	R	Initials of the person receiving treatment Returned in P4 of the response message

Patient Record Type 2Pb					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
5	Patient Full Name	An..30	ALL	M R	Full name(s) of the person receiving treatment. Returned in P5 of the response message
6	Patient DOB	Dt..8	ALL	R	Date of Birth of the person receiving treatment CCYYMMDD format (scheme specific) Returned in P6 of the response message
7	Patient Gender	An..1	ALL		Gender of the person receiving treatment. M Male F Female O Other (scheme specific)
8	Patient Relation Code	An..2	ALL		Code representing the relationship between the person receiving treatment and the Medical Fund member. 01 Main Member 02 Son 03 Spouse 04 Daughter 05 Mother 06 Father 07 - Other
9	Patient ID/Passport number	An..20	ALL	R	Patient ID/Passport Number (scheme specific) Returned in P7 of the response message
10	Recall Date	Dt..8	D		The date of the next visit for the patient. This is currently specific to dental claims and used for managed Healthcare.
11	COID Indicator	An..2	D,G,H	CM	01 COID Used to identify COID claims Empty by default
12	Date of Accident/Injury	Dt..8	D,G,H	CM	Date of accident / injury (CCYYMMDD) Mandatory for COID claims ie if P11 = 01
13	Employer Name	An..35	D,G,H	CM	Mandatory for COID claims ie if P11 = 01
14	Employer Registration Number	An..35		CM	Mandatory for COID claims ie if P11 = 01
15	Employee No	An..35	D,G,H		Employee number (for COID claims only ie if P11 = 01)
16	CIR/CC/ Insurance No	An..35	D,G,H		CIR (Commissioner Issued Reference Number) / CC / Insurance number.
17	Authorization No	An..20		R	Medical Scheme authorization number for this claim Returned in P8 of the response message

Patient Record Type a Pb					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
18	Confirmation No	An..20		R	Confirmation number given verifying a valid authorization number Returned in P9 of the response message
19	Account No	An..15		R	service providers PMA. (Used if service provider allocates a unique account number to each patient / dependant) Returned in P10 of the response message
20	Outpatient/ Hospital Patient	An..2	H	CM	In / Out Hospital Indicator 01 = Outpatient 02 = In Hospital Patient Returned in P11 of the response message Mandatory for hospital claims
21	Patient Height	I..3	H, G		Specified in centimeters with no decimals and rounded down
22	Patient Weight	I..6	H, G		Specified in grams with no decimals and rounded down
23	PMA Claim Reference Number	An..10	ALL	MR	Unique number generated by the PMA to identify this claim / invoice This number is returned in P12 of the response message

Hospital Admission Record a b

Hospital Admission Record Type a b					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..2	ALL	M	
2	Admission Date/Time	Dt..12	H	M	Date and time of admission into hospital (CCYYMMDDhhmm).
3	Type of Service	An..2	H		Type of Service being performed: 01 Medical 02 Maternity 03 Surgical 05 Emergency

Hospital Discharge Record a b

Hospital Discharge Record Type a b					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..2	ALL	M	

Hospital Discharge Record Type a b SwitchClaim Request Format					
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
2	Discharge Date/Time	Dt..12	H	CM	Date and time discharged from hospital (CCYYMMDDhhmm).
3	Disposal Code	An..2	H		01 Home or self care 02 Discharge to another short term facility 03 Stepdown 04 Discharge to another type of facility 05 Home nursing 06 Left against medical advise 07 Home IV service 08 Neonatal ICU 09 Neonatal high care 10 Expired (died) 11 Still an inpatient

Doctor Record a b

Doctor Record Type aDRb SwitchClaim Request Format					
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..2	ALL	M	
2	Doctor PCNS number	An..18	ALL	M	Doctor PCNS number
3	Doctor Name	An..30	ALL		Doctor name.
4	Doctor Type Code	An..2	ALL	M	01 Attending/Treating/Prescribing Doctor 02 Assisting Doctor 03 Anaesthetist 04 - Admitting Doctor 05 - Referring Doctor 06 Referred to Doctor 07 Discharging Doctor
5	Registration Number	An..20	ALL	CM	type in DR6 Mandatory if DR4 = 01
6	CMS Doctor Type Indicator	An..2	ALL	CM	Council of Medical Schemes Types: 01 HPCSA 02 A HPCSA 03 SACSSP 04 SADTC 05 SANC 06 SAPC Mandatory if DR4=01
7	Dispensing No	An..20		CM	Mandatory for dispensed medicine claims
8	Designated Service Provider Indicator	An..1			Y or N (Refer to Annexure A:4 for a list of reasons)

9	Doctor Tracking Number	An..15			Referring / Referred to doctor tracking number.

Doctor Diagnosis Record a b

Doctor Diagnosis Record Type aDb					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..1	G,D,H	M	
2	Doctor Type Code	An..2	ALL	M	Used to differentiate between the attending, admitting, referring and discharging doctor diagnosis ie 01 = Attending Doctor / Prescribing 02 = Admitting Doctor 03 = Referring Doctor 04 = Discharging Doctor
3	Diagnosis Code Type	An..2	G,D,H	M	Indicate the diagnosis code type for the above code. Possible values are: 01 ICD10 02 ICD-DA (Dental) 03 Free Text (Specify in D5)
4	Diagnosis Code	An..10	G,D,H	CM	Doctor Diagnosis Code Mandatory if D3 is not equal to 03
5	Diagnosis Description	An..70	G,D,H	CM	Free text describing the Doctor Diagnosis Mandatory if D3 = 03 (Free Text)
6	Extended Diagnosis	An..2	G,D,H	M	Indicates whether this diagnosis is primary, secondary, a co-morbidity or a complication. Possible values are: 01 Primary 02 Secondary 03 Co-Morbidity 04 Complication 05 Allergy

Treatment Record a b

Treatment Record Type aTb					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..1	ALL	M	
2	Treatment number	I..4	ALL	M	Sequential number for this treatment within

Treatment Record Type aTb					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
3	Treatment Start Date/Time	Dt..12	ALL	CM R	Start date and time of the treatment. Use the CCYYMMDDhhmm format. CCYYMMDD mandatory hhmm optional Returned in T2 of the response message
4	Treatment End Date/Time	Dt..12	ALL	CM R	End date and time of treatment. Use the CCYYMMDDhhmm format. Mandatory if the end date is not the same as the start date CCYYMMDD mandatory hhmm optional Returned in T3 of the response message
5	Authorization No	An..20	H,G,P	R	Used to populate an authorization number provided by the scheme. For claim reversals, use the original authorization number received from the Medical Scheme to populate this field. Returned in T4 of the response message
6	PMA Script / Lab Invoice Number	An..20	ALL	R	Unique number generated by the PMA to identify this prescription / lab invoice This number is returned in T5 of the response message
7	PMA Claim Line Number	An..20	All	CM R	Unique reference number generated by the PMA to identify this treatment line Mandatory for Consultation, Procedure and Material Claims. This number is used to link MSR and SwitchOn responses to the original claim lines and for the auto allocation and reconciliation of eRA responses Returned in T6 in the response message.
8	Treatment type Indicator	An..2	ALL	M R	The type of treatment received: 01 Dispensed Medicine 02 Tariff 03 Modifier (use for modifiers that are billed on their own lines - without tariff codes and with their own monetary values) Returned in T8 of the response message

Treatment Record Type a Tb					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
9	Quantity / Number of Units	N..8	ALL	M R	The quantity or number of units applicable to the Unit Type in T10. Default = 100 Returned in T9 of the response message
10	Quantity / Unit Type Indicator	An..2	ALL	M	Applicable to quantity / number of units in T9 01 Day 02 Hour 03 Minute 04 Second 05 Kilometer 06 Unit (default) 07 Item (used for dispensed medicines and lab invoices to identify the number of medicines/items included with this script/claim) 08 Theatre Time (Indicate number of minutes in T9) Returned in T10 of the response message
11	Tariff / Procedure / Modifier Code	An..15	ALL	CM R	The tariff / procedure / modifier/medicine item tariff code for this treatment Mandatory if T8 is not equal to 01 (Dispensed Medicine) Returned in T10 of the response message
12	Tariff Code Type / Procedural Coding Standard	An..2	ALL	M	Indicator to show what type of tariff code has been sent in field T11. Allowable values are: 01 NHRPL 02 NAPPI (use if T8 = 01) 03 CPT / CCSA (CPT) 04 CDT 05 SAOA (South African Optometric Ass) 06 Orthotist 07 UPFS
13	Modifier Type	An..2	ALL		Used to identify the type of Modifier: 01 = Informational Modifier 02 = Reduction Modifier 03 = Add Modifier 04 = Compound Modifier
14	NAPPI Code	An..9	ALL	CM R	NAPPI code for this item. This field is only used for consumables where the Dispensed Medicine Record (C Record) is not part of the treatment, also Returned in T11 of the response message.
15	Service Rate / Pricing Tariff Indicator	An..2	ALL		Used to indicate the rate / pricing standard used: 01 NHRPL 02 COID 03 Fund Tariff 04 Managed Fee for Service 05 Group Capitation 06 Individual Capitation 07 Ethical Tariff Rates (HPCSA)

Treatment Record Type aTb					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
					08 SAMA 09 SADA 10 SAOA 11 HASA 12 Fixed Fee (Hospital) 13 Per Diem (Hospital) 14 UPFS
16	Tariff / Modifier / Treatment Description	An..70	ALL	R	Description of the tariff / modifier code or treatment Returned in T12 of the response message
17	Registered PMB Condition	A..1			Diagnosis record D to describe indicated PMB condition.
18	Script Written Date	Dt..8	G,P		Date prescription was written.
19	Benefit Type Indicator	An..2	G,P	R	Benefit Type Indicator: 01 Acute (Default) 02 Chronic 03 Over the Counter / PAT 04 Chemotherapy Returned in T13 of the response message
20	Hospital Tariff Type	An..2	H		Used for in-hospital claims to indicate the type of treatment: 01 Ward Fees 02 Theatre Fees 03 TTO 04 Ward Extra 05 Gas 06 Dispensed Drugs 07 Exclusions 08 Ward Drugs 09 Theatre Drugs 10 Miscellaneous 11 Theatre Extra 12 Dispensary Fees 13 Management Fees
21	Laboratory PCNS or Council Registration number	An..18	D		Dental or Pathology laboratory PCNS number or Council registration number.
22	Laboratory reference number	An..32	D	R	Dental or Pathology laboratory reference number Returned in T14 of the response message
23	Laboratory Name	An..20	D		Dental or Pathology laboratory name.
24	Re-submission Reason Code	An..2	ALL		Code indicating the reason for a claim being resubmitted: 01 Unpaid 02 Details Changed This field should be blank by default. Populate this field with one of the above codes when a previously transmitted claim line is re-submitted / re-sent.

Treatment Record Type aTb					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
25	Original Claim / Script / Invoice number	An..20	ALL	CM	The original unique number generated by the PMA to identify this claim / prescription / lab invoice Mandatory when resubmitting / resending claims. Empty by default
26	Date/Time Original Claim / Script / Invoice file was created	Dt..12	ALL	CM	Date/Time stamp the claim file was originally created (CCYYMMDDhhmm) Mandatory when resubmitting / resending claims Empty by default
27	PHISC Place of Service Code	An..2	H	CM	PHISC Place of Service Code. (refer to Annexure A:2) Primarily used to differentiate between in and out hospital patient treatments Mandatory for treatments provided to in-hospital patients

Procedure Record a b

Procedure Record Type aPRb					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..2	H	M	
2	Procedure Code	An..15	H	M	Procedure code.
3	Procedure Code Type	An..2	H	M	Procedure code type / standard: 01 NHRPL 02 CPT / CCSA 03 CDT
4	Procedure Description	An..70	H	M	Procedure Description.

Modifier Record Type a Db

Modifier Record Type a Db					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..2	ALL	M	
2	Modifier Code	An..15	ALL	M	Used to submit modifier codes that are billed in the same line as the tariff with a single value

3	Modifier Type	An..2	ALL		Used to identify the type of Modifier: 01 Informational Modifier 02 Reduction Modifier 03 Add Modifier 04 Compound Modifier

Optical Record a b

Optical Record Type a OPb					**SwitchClaim Request Format**
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..2	O	M	
2	Item No	I..2	O	M	Sequence number of this item within the record.
3	Frame Supplier Name	An..50	O		Frame Supplier Name.
4	Frame Model Name	An..50	O		Frame model name.
5	Frame Model Number	An..5			Frame model number
6	Frame Size	An..8			Frame size
7	Eye L/R	An..1	O		L Left eye R Right eye
8	Lens Prescription Sphere	N..5	O		Sphere (Abbreviation: SPH): This is the amount of Short-sightedness or Long-sightedness expressed in Dioptres (a function of the focal length).
9	Lens Prescription Cylinder	N..5	O		Cylinder (Abbreviation: CYL): This indicates the amount of astigmatism resent in the eye. Cyl values (also expressed in dioptres) always have a negative value.
10	Lens Prescription Axis	N..5	O		Axis (major plane): This describes the axis of astigmatism.
11	Lens Prescription Reading Additions	N..5	O		This is the additional strength used in a multifocal lens.
12	Lens Prescription Prism	N..5	O		Prism: This lens component is used as an aid for correcting muscle imbalances and squints.
13	Lens Prescription Base	An..15	O		Base: This describes the direction of the prism base: In, Out, Up and Down and the intermediates In and Up, In and Down, Out and Up and Out and Down.
14	Density of Tint	An..6	O		Density of tint specified per eye.
15	Description	An..70	O		Description of the lens or frame.

Tooth Record a b

Tooth Record Type aNb					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..1	D	M	
2	Tooth Number	I..2	D	M	Number of the tooth. Format of this number is: First digit indicates the quadrant in the mouth. Adults: Quad 1 4 ; 8 permanent teeth/quad. Second digit indicates the tooth in the quadrant. Children: Quad 5 8 ; 5 milk teeth/quad.
3	Tooth Surface	A..7	D		This field indicates the surface(s) on which the preceding treatment was performed. There are 7 possible entries, each of which should be sent if that surface was worked on. The possible entries are: B Buccal D Distal O Occlusal L Lingual I Incisal P Palletal M Measal
4	Super-Numary Tooth Indicator	A..1	D		-numary tooth was worked on.

General Comments Record a b

General Comments Record Type aGb					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..1	ALL	M	
2	General Comments	An..512	ALL	M	General comments.

File Attachment Record a b

File Attachment Record Type aAb					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..1		M	

2	File Name	An..128			Name of the file. The contents of the attachment would be separated from the claim by a NULL (0) character, and would be followed by a NULL (0) character. If multiple files are attached, it would be separated by a single NULL (0) character.
3	File Size	I..7		M	Size of the attachment in bytes. The total transaction size may not exceed 5 Megabytes.

Dispensed Medicine Record a b

Dispensed Medicine Record Type a Cb SwitchClaim Request Format					
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..1	ALL	M	
2	Mixture Indicator	An..1	ALL	M R	Y/N To indicate if this item is a mixture Returned in C2 of the response message
3	Mixture Ingredient No	I..2	P	M R	Sequence number of ingredient within a all records that are not an ingredient that forms part of a mixture mixture, then increment by 1 for each new ingredient. Returned in C3 of the response message
4	Mixture Ingredient/Unit Cost	N..9	P	CM	Gross cost of an ingredient within a mixture. Mandatory if C2 = Y and C3>0
5	Medicine Type	An..2	P	CM	An indicator for the type of mixture dispensed: 01 Drops 02 Liquid (Default) 03 Cream 04 Powder
6	NAPPI Code	An..9	ALL	M R	NAPPI code for this item. Returned in C4 of the response message
7	EAN Code	An..15	ALL		EAN code for this item.
8	Item Description	An..70	ALL	M R	Description of the item. Returned in C7 of the response message

Dispensed Medicine Record Type a Cb SwitchClaim Request Format					
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
9	Quantity / Number of Units dispensed	N..10	ALL	M R	Total quantity of the item dispensed. For a mixture header, this is the total quantity of all ingredients. Where a pack can be broken, the individual quantity must be specified e.g. 200 (ml liquid); 15 (tablets) etc. drops, a quantity of 1 is specified. Returned in C8 of the response message
10	Daily Dosage	I..6	G,P		Number of doses per day.
11	Days of Therapy	I..3	G,P	M	Number of days of supply.
12	Basis of Days of Therapy	An..2	G,P		calculated. 01 Not Specified 02 On Script / Implicit Usage 03 Dispensers Estimation 04
13	Repeat Number	I..2	G,P		The number of this repeat.
14	Repeats Authorised	I..2	G,P		Total number of repeats authorized.
15	Original Prescription Number	An..20	G,P		The number of the original script filled in the case of a repeat.
16	DAW	An..2	G,P		Dispense as written code: 01 No DAW (Default) 02 Dr. DAW 03 Pat. DAW 04 Rph. DAW 05 No generic available 06 Brand dispensed as generic
17	Benefit Type Indicator	An..2	G,P	M	Benefit Type Indicator: 01 Acute (Default) 02 Chronic 03 Over the Counter / PAT 04 Chemotherapy
18	Authorisation No	An..20	G,P	R	The authorization number provided by the medical scheme for this medicine item Returned in C10 of the response message
19	Basis of Price	An..2	G,P		How the price was calculated: 01 Single Exit Price (SEP) 02 Avg Wholesale Price 03 Avg Wholesale + Amount 04 Avg Wholesale + % 05 Other (Default)

Dispensed Medicine Record Type aCb SwitchClaim Request Format					
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
20	PMA Medicine Item Line Number	An..20	G,P	M R	Unique number for this medicine generated database. This number is used to link MSR and SwitchOn responses to the original claim lines and for the auto allocation and reconciliation of eRA responses Returned in C12 of the response message.
21	Re-Submission Reason Code	An..2	G,P		Code indicating the reason for a dispensed medicine being resubmitted: 01 Unpaid 02 Details Changed This field should be blank by default. Populate this field with one of the above codes when a previously transmitted dispensed medicine is re-submitted.

Laboratory Record a b

Laboratory Record Type aLb SwitchClaim Request Format					
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..1	D	M	
2	Item No	I..2	D	M	Sequence number of this item within the
3	Lab Item Tariff Code	An..15	D	M R	Lab tariff code. Returned in L2 of the response message
4	Lab Tariff Description	An..70	D	R	Item description of tariff code. Returned in L3 of the response message
5	Quantity / Number of Units	N..9	D	M R	Number of items / units Returned in L4 of the response message
6	PMA Item Line Number	An..20	D	M R	Unique number generated by the PMA for this Lab Item This number is used to link MSR and SwitchOn responses to the original claim lines and for the auto allocation and reconciliation of eRA responses Returned in L5 of the response message

Item Financial Record a b

Item Financial Record Type a/b					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..1	ALL	M	
2	Item Net Amount / Price (inclusive of VAT)	N..12	ALL	M	Item net amount / price (ie Single Exit Price or Wholesale Price or Shelf price of item) for or Lab Item net record
3	Item Gross Amount / Price (inclusive of VAT)	N..12	ALL	M	Item Gross amount / price plus markup / fees ie Y3 = Y2 + Y4 + Y5 + Y6 + Y7
4	Item Dispensing Fee / Mark-up	N..12	P		Dispensing fee / mark-up for the item reflected on the preceding C record
5	Container Fee	N..12	P		Container fee for the item reflected in the preceding C record
6	Excess Time Fee	N..12	P		The excess time fee charged for the additional time devoted to the compounding and/or manufacture of the item reflected in the preceding C record.
7	Item Contract Fee	N..12			Contract Fee for the item reflected in the preceding C record
8	Item Claimed Amount	N..12	ALL	M	Item Gross amount less discount amount ie Y8 = Y3 Y9
9	Discount Amount	N..12	ALL		Item discount amount
10	Patient Levy Amount	N..12	ALL		The patient levy amount for this item to be collected at the point of service
11	MMAP Surcharge Amount	N..12	G,P		In the instance where the Medical Fund has adopted the MMAP program, but the patient chooses to take a higher-priced non-MMAP product the patient is liable for the difference in the prices of the respective products the difference is referred to as the MMAP surcharge this is payable by the member.
12	Item Co-Payment Amount	N..12	ALL		The patient co-payment amount for this item
13	Item Patient Liable Portion	N..12	ALL		The patient levy amount plus the MMAP surcharge amount plus the patient co-payment amount for this item (ie Y13 = Y10 + Y11 + Y12)

Item Financial Record Type aYb					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
14	Item Medical Fund Liable Amount	N..12	ALL		Item claimed amount less item patient liable amount (ie Y14 = Y8 Y13)
15	Member Reimbursement Amount	N..12	ALL		Used to Identify a Member Paid Claim and the amount to be reimbursed by the scheme to the member. Field to be populated with the medical fund liable amount that was paid by member / patient for this item.

Treatment Financial Record a b

Treatment Financial Record Type aZb					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..1	ALL	M	
2	Treatment / Prescription Net Amount	N..12	ALL	M	Net price for the treatment / prescription reflected in the preceding T record or Summation of item net amounts for the preceding Y records (following each C or L record) ie Z2 = (SUM Y2)
3	Treatment / Prescription Gross Amount	N..12	ALL	M	Gross price for the treatment / prescription reflected in the preceding T record plus mark-up / fees ie Z3 = Z2+Z4+Z5+Z6+Z7+Z8+Z9+Z10 or Summation of item gross amounts for the preceding Y records (following each C or L record) Ie Z3 = (SUM Y3)

Treatment Financial Record Type a2b					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
4	Total Dispensing Fee / Mark-up for Prescription	N..12	P		Summation of item dispensing fees / mark-ups for

Treatment Financial Record Type aZb SwitchClaim Request Format					
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
14	MMAP Surcharge	N..12	G,P		Summation of item MMAP surcharge amounts for the preceding Y records (following each C record) Ie Z14 = (SUM Y11)
15	Treatment / Prescription Patient Co-Payment Amount	N..12	ALL		Patient co-payment amount for the treatment / prescription reflected in the preceding T record or Summation of patient co-payment amounts for the preceding Y records (following each C or L record) Ie Z15 = (SUM Y12)
16	Treatment / Prescription Patient Liable Portion	N..12	ALL		Patient levy amount plus MMAP surcharge amount plus patient co-payment amount for the treatment / prescription reflected in the preceding T record (ie Z16 = Z13 + Z14 + Z15) or Summation of treatment / prescription patient liable amounts for the preceding Y records (following each C or L record) Ie Z16 = (SUM Y13)
17	Treatment / Prescription Medical Fund Liable Amount	N..12	ALL		Claimed amount less patient liable amount for the treatment / prescription reflected in the preceding T record (ie Z17 = Z11 Z16) or Summation of treatment / prescription medical fund liable amounts for the preceding Y records (following each C or L record) Ie Z17 = (SUM Y14)
18	Member Reimbursement Amount	N..12	ALL		Used to Identify a Member Paid Claim and the amount to be reimbursed by the scheme to the member. Field to be populated with the medical fund liable amount that was paid by member / patient for this treatment / prescription. F18 = (SUM Y15)

Claim Financial Record a b

Claim Financial Record a b SwitchClaim Request Format					
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..1	ALL	M	
2	Claim Net Amount	N..12	ALL	M	Net amount of the claim for the patient reflected in the preceding P record or Summation of treatment / prescription net amounts for the preceding Z records following each T record for the same patient (P record) ie F2 = (SUM Z2)
3	Claim Gross Amount	N..12	ALL	M	Gross amount of the claim for the patient reflected in the preceding P record or Summation of treatment / prescription gross amounts for the preceding Z records following each T record for the same patient (P record) ie F3 = (SUM Z3)
4	Total Claimed Amount	N..12	ALL	M	Claim gross amount less claim discount amount ie F4 = F3 F5 or Summation of treatment / prescription claimed amounts for the preceding Z records following each T record for the same patient (P record) ie F4 = (SUM Z11)
5	Claim Discount Amount	N..12	ALL		Claim discount amount or Summation of treatment / prescription discount amounts for the preceding Z records following each T record for the same patient (P record) ie F5 = (SUM Z12)
6	Claim Deductible / Levy Amount	N..12	ALL		Claim cumulative levy amount collected at the point of service or Summation of treat,emt / prescription deductible / levy amounts for the preceding Z records following each T record for the same patient (P record) Ie F6 = (SUM Z13)
7	Claim MMAP Surcharge	N..12	G,P		Summation of prescription MMAP surcharge amounts for the preceding Z records following each T record for the same patient (P record)

Claim Financial Record a b					SwitchClaim Request Format
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
					Ie F7 = (SUM Z14)
8	Claim Co-Payment Amount	N..12	ALL		Scheme co-payment amount for the claim for the patient reflected in the preceding P record or Summation of treatment / prescription co-payment amounts for the preceding Z records following each T record for the same patient (P record) Ie F8 = (SUM Z15)
9	Receipt No	An..10	ALL		Receipt number issued to patient for payment.
10	Claim Patient Liable Portion	N..12	ALL		Levy amount plus MMAP surcharge amount plus co-payment amount for the claim for the patient reflected in the preceding P record (ie F10 = F6 + F7 + F8) or Summation of treatment / prescription patient liable amounts for the preceding Z records following each T record for the same patient (P record) Ie F10 = (SUM Z16)
11	Claim Medical Fund Liable Amount	N..12	ALL		Total claimed amount less patient liable amount for the claim for the patient reflected in the preceding P record ie F11 = F4 F10 or Summation of treatment / prescription medical fund liable amounts for the preceding Z records following each T record for the same patient (P record) Ie F11 = (SUM Z17)
12	Member Reimbursement Amount	N..12	ALL		Used to Identify a Member Paid Claim and the amount to be reimbursed by the scheme to the member. Field to be populated with the medical fund liable amount that was paid by member / patient for this claim. F12 = (SUM Z18)

Footer (End of Message) Record a b

Footer (End of Message) Record a b SwitchClaim Request Format					
FIELD NO	**FIELD NAME**	**FORMAT**	**REQ**	**MAN**	**REMARKS**
1	Record Type	A..1	ALL	M	
2	Transmission Number	I..10	ALL	M	Unique sequential number generated by the PMA to identify this claim/group of claims. request record. This number is returned in H2 and E2 of the response message
3	Number of Claims	I..3	ALL	M	Total number of claims (P records) in the file.
4	Value of Claims	N..12	ALL	M	Total value of claims in the batch. (This is a control total of the sum of the applicable net amounts in Z2 records or the sum of the applicable net amounts in the F2 records).

Response Message Structure

```
{
 Type H
 {
  [
   Type S
   Type M
   Type P
   {
    Type T
    {
     [
      Type C
      [
       {
        Type C
        { [ Type R ] }
        { [ Type U ] }
        { [ Type G ] }
        Type Y
       }
      ]
      { [ Type R ] }
      { [ Type U ] }
      { [ Type G ] }
      Type Y
     ]
     [
      {
       Type L
       { [ Type R ] }
       { [ Type G ] }
       Type Y                          (Note : Mixture Total)
      }
     ]
     { [ Type R ] }
     { [ Type G ] }
    }
    Type Z
    { [ Type R ] }
    { [ Type G ] }
    { [ Type FR ] }
   }
   Type F
  ]
 }
 { [Type G] }
  Type E
}
```

LEGEND:

Note: In the case of mixtures, a Y record per ingredient as well as a summation Y record for the mixture ingredient may be returned.

Note: Medical Schemes may only supply financial information on a header level on some responses, if returned at all. Therefore some line level responses may ha
though the

Response Message Records

Header (Start of Message) Record a b

Header (Start of Message) Record Type aHb SwitchClaim Response Format				
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
1	Record Type	A..1	M	
2	Transmission Number	I..10	M	The original number transmitted in H2 and E2 of the request message. This number used to identify this claim/group of claims. This number is also returned in E2 of the response record

Service Provider Record a b

Service Provider Record Type aSb SwitchClaim Response Format				
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
1	Record Type	A..1	M	
2	Response File Creation Date/Time	Dt..12	M	Date/Time stamp the response file was created (CCYYMMDDhhmm).
3	Billing Practice PCNS number	An..18	M	PCNS number of Billing Practice
4	Billing Practice Name	An..40		Name of Billing Practice
5	PMA Dataset Identifier	An..50		The PMA dataset from which the claim originated. If populated in the request message this field is returned to enable the PMA to link back the response message to the corresponding dataset submitted with the original request message.
6	Reject Count	I..3		Number of claim line rejections/errors.

Member Record a b

Member Record a b SwitchClaim Response Format				
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
1	Record Type	A..1	M	
2	Member Surname	An..30	M	Surname of the principal Medical Fund member.
3	Member Full Names	An..30	M	First name(s)/initials of the Medical Fund member.
4	Membership Number	An..20	M	Medical Fund membership number.

Member Record a b				SwitchClaim Response Format
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
5	PMA Account No	An..15	M	The member's account number in the service providers PMA as transmitted in M9 of the request message
6	Medical Scheme Name	An..20		The name of the medical scheme
7	Medical Scheme Registration Number	An..15		Registration number of Medical Scheme
8	SwitchOn Destination Code	An..8	M	SwitchOn Destination Code for the Medical Scheme / Plan
9	Destination Contact Number	An..20		Telephone number of the destination call centre / help desk

Patient Record a b

Patient Record a b				SwitchClaim Response Format
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
1	Record Type	A..1	M	
2	Dependant Code	An..3		
3	Patient Surname	An..30	M	Patient's surname
4	Patient Initials	An..5		
5	Patient Full Name	An..30	M	
6	Patient DOB	Dt..8		Date of Birth of the person receiving treatment CCYYMMDD format.
7	Patient ID/Passport number	An..20		
8	Authorization No	An..20		Medical Scheme authorization number for this claim
9	Confirmation No	An..20		Confirmation number given verifying a valid authorization number
10	Account No	An..15		PMA as transmitted in P19 of the request message
11	Outpatient/ Hospital Patient	An..2		The In / Out Hospital Indicator submitted in P20 of the request message
12	PMA Claim Reference Number	An..10	M	Unique number generated by the PMA to identify this claim / invoice and submitted in P23 of the request message
13	Response / Status Level Indicator	An..2	M	Indicates at what level the response is given 01 = Patient (P) record 02 = Treatment (T) record 03 = Item (C or L) record

Patient Record a b				SwitchClaim Response Format
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
14	Response Result Code	An..2		Indicates type of response message being sent at claim level: 01 = Claim Accepted for delivery 02 = Claim Accepted for processing 03 = Claim Rejected 04 = Claim Approved for Payment 05 = Claim Approved for Part Payment 06 = Claim Reversal Accepted 07 = Claim Reversal Rejected
15	Responding Party	An..2		01 = MediSwitch 02 = Medical Scheme / Administrator
16	MediSwitch Delivery Type Indicator	An..2	CM	Delivery Type Indicator: 01 = Real-Time 02 = Batched 03 = Queued 04 = Rejected For a delayed response the Indicator field will be empty

Treatment Record a b

Treatment Record a b				SwitchClaim Response Format
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
1	Record Type	A..1	M	
2	Treatment Start Date/Time	Dt..12	M	Start date/time of treatment.
3	Treatment End Date/Time	Dt..12		End date/time of treatment.
4	Authorisation Number	An..20		Medical Scheme authorization number for this treatment
5	PMA Script /Lab Invoice Number	An..20		The original prescription / invoice number submitted in T6 of the request record
6	PMA Claim Line Number	An..20		Unique reference number generated by the PMA for this treatment line, as submitted in T7 of the request message. This number is used to link the response to the original request.
7	Scheme / Destination Claim reference tracking number	An..12		Medical scheme / destination claim reference tracking number
8	Treatment Type Indicator	An..2		The type of treatment received (as submitted in T8 of the request format): 01 Dispensed Medicine 02 Tariff 03 Modifier

Treatment Record a b				SwitchClaim Response Format
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
9	Quantity / No of Units	N..8		The quantity or number of units
10	Tariff / Procedure / Modifier Code	An..15		The tariff / procedure / modifier code for this treatment, as submitted in T11 of the request format.
11	NAPPI	An..9		NAPPI code for this item
12	Tariff / Treatment Description	An..70		Description of the tariff code or treatment
13	Benefit Type Indicator	An..2		Benefit Type indicator: 01 Acute (Default) 02 Chronic 03 Over the Counter / PAT 04 Chemotherap
14	Laboratory reference number	An..32		Dental or Pathology laboratory reference number, as submitted in T22 of the request format.
15	Response Result Code	An..2		Indicates type of response message being sent at treatment level: 01 = Treatment Accepted for delivery 02 = Treatment Accepted for processing 03 = Treatment Rejected 04 = Treatment Approved for Payment 05 = Treatment Approved for Part Payment 06 = Treatment Reversal Accepted 07 = Treatment Reversal Rejected
16	Responding Party	An..2	M	01 = MediSwitch 02 = Medical Scheme / Administrator
17	MediSwitch Delivery Type Indicator	An..2	CM	Delivery Type Indicator: 01 = Real-Time 02 = Batched 03 = Queued 04 = Rejected For a delayed response the Indicator field will be empty

Dispensed Medicine Record a b

Dispensed Medicine Record Type a Cb				SwitchClaim Response Format
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
1	Record Type	A..1	M	
2	Mixture Indicator	An..1	M	Y/N
3	Mixture Ingredient No	I..2	M	Sequence number of ingredient within a mixture. -mixture for first ingredient within a mixture, then increment by 1 for each new ingredient.

Dispensed Medicine Record Type aCb SwitchClaim Response Format				
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
4	NAPPI Code	An..9	M	NAPPI code for this item.
5	EAN Code	An..15		EAN Code.
6	MMAP	An..11		MMAP drug code.
7	Description	An..70	M	Description of this item
8	Quantity / Number of Units dispensed	N..10	M	Total quantity of the item dispensed. For a mixture, this is the total quantity of all ingredients. Where a pack can be broken, the individual quantity must be specified e.g. 200 (ml liquid); 15 (tablets) etc. of 1 is specified.
9	Benefit Type Indicator	An..2		Benefit Type Indicator: 01 Acute (Default) 02 Chronic 03 Over the Counter / PAT 04 Chemotherapy
10	Authorisation No	An..20		The authorization number provided by the medical scheme for this medicine item
11	Basis of Reimbursement	An..2		How the reimbursement amount was calculated: 01 Single Exit Price (SEP) 02 Avg Wholesale Price 03 Avg Wholesale + Amount 04 Avg Wholesale + % 05 Other (Default)
12	PMA Medicine Item Line Number	An..20	M	The unique reference number generated by the PMA for this medicine item, as submitted in C21 of the request message This number is used to link the response to the original request
13	Number of DUR Messages	I..2	M	
14	Response Result Code	An..2		Indicates type of response message being sent at item level: 01 = Item Accepted for delivery 02 = Item Accepted for processing 03 = Item Rejected 04 = Item Approved for Payment 05 = Item Approved for Part Payment 06 = Item Reversal Accepted 07 = Item Reversal Rejected
15	Responding Party	An..2	M	01 = MediSwitch 02 = Medical Scheme / Administrator

DUR Record a b

DUR Record Type a Ub				SwitchClaim Response Format
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
1	Record Type	A..1	M	
2	DUR Severity Indicator	An..2		Severity of DUR Message that follows: 00 Not Specified 01 Major 02 Moderate 03 Minor
3	DUR Item No	An..1		Corresponding Item number.
4	DUR Add Info Indicator	An..1		Signals that additional DUR information from the processor is available. 0 - not specified 1 - no additional info available 2 additional info available The practice should contact the processor for the additional information.
5	Drug Conflict Code	An..2		DUR type of utilization conflict that was detected. Tabulation can be found in Annexure A:3.
6	Other Pharmacy / Dispensing Practitioner Indicator	An..2		DUR Source of prior conflicting prescription: 01 Same Pharmacy / Dispensing Practitioner 02 Different Pharmacy / Dispensing Practitioner, Same Chain 03 Different Pharmacy/ Dispensing Practitioner, Different Chain
7	Previous Date of Fill	Dt..8		DUR the previous date the prescription was filled.
8	Quantity of Previous Fill	I..5		DUR metric quantity of the conflicting agent that was previously filled.
9	Other Prescriber Indicator	An..1		DUR compares prescriber of current prescription to prescriber of previously filled conflicting prescription. 0 - no value or not applicable 1 - same prescriber 2 - other prescriber
10	Comments1	An..50		General comments.
11	Comments2	An..80		General comments.
12	Comments3	An..172		General comments.
13	Database Indicator	An..1		Database indicator. Identifies the source of the message. 1 - first databank 2 - medi-span 3 - redbook 4 - processor developed 5 - other

Laboratory Record a b

Laboratory Record a b				SwitchClaim Response Format
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
1	Record Type	A..1	M	

2	Lab Item Tariff Code	An..15	M	Lab item tariff code.
3	Lab Tariff Description	An..70		Item description of tariff code.
4	Quantity / Number of Units	N..8	M	Number of items / units
5	PMA Item Line Number	An..20	M	The unique reference number generated by the PMA for this item, as submitted in L6 of the request message This number is used to link the response to the original request.
6	Authorization No	An..20		Item authorization number provided by the medical scheme
7	Response Result Code	An..2		Indicates type of response message being sent at item level: 01 = Item Accepted for delivery 02 = Item Accepted for processing 03 = Item Rejected 04 = Item Approved for Payment 05 = item Approved for Part Payment 06 = Item Reversal Accepted 07 = Item Reversal Rejected
8	Responding Party	An..2	M	01 = MediSwitch 02 = Medical Scheme / Administrator

Response Record a b

Response Record Type aRb				**SwitchClaim Response Format**
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
1	Record Type	A..1	M	
2	Response Code	An..6	M	Response code from MediSwitch or Medical Fund
3	Response Description	An..60	M	Description of response from MediSwitch or Medical Fund.

General Comments Record a b

General Comments Record Type aGb				**SwitchClaim Response Format**
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
1	Record Type	A..1	M	
2	General Comments	An..512	M	General comments.

Failure Response Record a FRb

Failure Response Record Type a b SwitchClaim Response Format				
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
1	Record Type	A..1	M	
2	Failure Response Message	An..512	M	Failure Response Message

Item Financial Record a b

Item Financial Record a b SwitchClaim Response Format				
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
1	Record Type	A..1	M	
2	Item Net Amount (inclusive of VAT)	N..12	M	Item net amount, as calculated by the medical scheme ie: Item net amount / price (ie Single Exit Price or Wholesale or
3	Item Gross Amount (inclusive of VAT)	N..12	M	Item gross amount as calculated by the medical scheme ie Item net amount plus markup / fees ie Y3 = Y2 + Y4 + Y5 + Y6 + Y7
4	Item Dispensing Fee / Mark-up	N..12		Dispensing fee / mark-up for the item reflected on the preceding C or L record, as calculated by the medical scheme
5	Container Fee	N..12		Container fee for the item reflected in the preceding C record, as calculated by the medical scheme
6	Excess Time Fee	N..12		Excess time fee for the item reflected in the preceding C record, as calculated by the medical scheme.
7	Contract Fee	N..12		Contract Fee for this item, as calculated by the medical scheme
8	Item Claimed Amount	N..12	M	Item claimed amount as submitted in Y8 of the request message
9	Discount Amount	N..12		Item discount amount, as calculated by the medical scheme

Item Financial Record a b				SwitchClaim Response Format
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
10	Item Overcharged Amount	N..12		Amount overcharged by provider for this item, as calculated by the medical scheme ie this amount is not payable by the patient so will not form part of patient liable amount.
11	Patient Levy Amount	N..12		The patient levy amount, as calculated by the medical scheme
12	MMAP Surcharge Amount	N..12		The MMAP surcharge amount, as calculated by the medical scheme ie the MMAP surcharge payable by the member.
13	Patient Co-Payment Amount	N..12		The patient co-payment amount, as calculated by the medical scheme
14	Item Patient Liable Portion	N..12		The patient liable portion for this item, as calculated by the medical scheme ie Item Levy amount plus MMAP surcharge amount plus item co-payment amount (ie Y14 = Y11 + Y12 + Y13)
15	Item Medical Fund Liable Amount	N..12		The medical fund liable amount for this item as calculated by the medical scheme ie item claimed amount less item patient liable amount (ie Y15 = Y8 Y14)
16	Amount Authorized for Payment to Provider	N..12		Amount authorized by the medical scheme for payment to the provider for this item
17	Member Reimbursement Amount	N..12		Amount authorized by the medical scheme for reimbursement to the patient for this item

Treatment Financial Record a b

Treatment Financial Record a b				SwitchClaim Response Format
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
1	Record Type	A..1	M	
2	Treatment / Prescription Net Amount	N..12	M	Net amount for this treatment, as calculated by the medical scheme ie Net price for the treatment / prescription reflected in the preceding T record or Summation of item net amounts for the preceding Y records (following each C or L record) ie Z2 = (SUM Y2)

Treatment Financial Record		a b		SwitchClaim Response Format
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
3	Treatment / Prescription Gross Amount	N..12	M	Gross amount for this treatment, as calculated by the medical scheme ie Net price for the treatment / prescription reflected in the preceding T record plus mark-up / fees ie Z3 = Z2+Z4+Z5+Z6+Z7+Z8+Z9+Z10 or Summation of item gross amounts for the preceding Y records (following each C or L record) Ie Z3 = (SUM Y3)
4	Total Dispensing Fee / Mark-up for Prescription	N..12		Dispensing fee / mark-up for this prescription, as calculated by the medical scheme ie Summation of item dispensing fees / mark-ups for the preceding Y records (following each C record) ie Z4 = (SUM Y4)
5	Total Container Fees for Prescription	N..12		Total amount for container fees for this prescription, as calculated by the medical scheme ie Summation of item container fees for the preceding Y records (following each C record) ie Z5 = (SUM Y5)
6	Excess Time Fee	N..12		Total excess time fees for this prescription, as calculated by the medical scheme ie Summation of the excess time fee charged for the additional time devoted to the compounding and/or manufacture of the item reflected in the preceding Y records (following each C record). ie Z6 = (SUM Z6)
7	Prescription Call-out Fee	N..12		Call-out fee or Late fee, for after hours prescription, as calculated by the medical scheme.
8	Prescription Copy Fee	N..12		Fee for providing a copy of the prescription, as calculated by the medical scheme
9	Prescription Delivery Fee	N..12		Fee for delivering the prescription, as calculated by the medical scheme.
10	Contract Fee	N..12		Total contract fee for this treatment / prescription, as calculated by the medical scheme ie Summation of contract fees for the preceding Y records (following each C or L record) ie Z10 = (SUM Y7)
11	Treatment / Prescription Claimed Amount	N..12	M	Treatment / Prescription claimed amount as submitted in Z11 of the request message or Z11 = (SUM Y8)

Treatment Financial Record		a b		SwitchClaim Response Format
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
12	Discount Amount	N..12		Treatment / Prescription discount amount, as calculated by the medical scheme ie Summation of item discount amounts for the preceding Y records (following each C or L record) Ie Z12 = (SUM Y9)
13	Treatment / Prescription Overcharged Amount	N..12		Total amount overcharged by provider for this treatment / prescription, as calculated by the medical scheme ie this amount is not payable by the patient so will not form part of the patient liable amount ie Z13 = (SUM Y10)
14	Patient Levy Amount	N..12		Treatment / Prescription patient levy amount, as calculated by the medical scheme or Summation of item patient levy amounts for the preceding Y records (following each C or L record) Ie Z14 = (SUM Y11)
15	MMAP Surcharge	N..12		Summation of item MMAP surcharge amounts, as calculated by the medical scheme for the preceding Y records (following each C record) Ie Z15 = (SUM Y12)
16	Treatment / Prescription Patient Co-Payment Amount	N..12		Patient co-payment amount, as calculated by the medical scheme for the treatment / prescription reflected in the preceding T record or Summation of item patient co-payment amounts for the preceding Y records (following each C or L record) Ie Z16 = (SUM Y13)
17	Treatment / Prescription Patient Liable Portion	N..12		Treatment / prescription patient laible portion as calculated by the medical scheme ie Patient levy amount plus MMAP surcharge amount plus patient co-payment amount for the treatment / prescription reflected in the preceding T record (ie Z17 = Z14 + Z15 + Z16) or Summation of treatment / prescription patient liable amounts for the preceding Y records (following each C or L record) Ie Z17 = (SUM Y14)
18	Treatment / Prescription Medical Fund Liable Amount	N..12		Treatment / prescription medical fund liable amount, as calculated by the medical scheme ie Claimed amount less patient liable amount for the treatment / prescription reflected in the preceding T record (ie Z18 = Z11 Z17)

Treatment Financial Record a b				SwitchClaim Response Format
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
				or Summation of treatment / prescription medical fund liable amounts for the preceding Y records (following each C or L record) Ie Z18 = (SUM Y15)
19	Amount Authorized for Payment to Provider	N..12		Amount authorized by the medical scheme for payment to the provider for this claim
20	Member Reimbursement Amount	N..12		Amount authorized by the medical scheme for reimbursement to the patient for this claim

Claim Financial Record a b

Claim Financial Record a b				SwitchClaim Response Format
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
1	Record Type	A..1	M	
2	Claim Net Amount	N..12	M	Net amount of the claim for the patient reflected in the preceding P record, as calculated by the medical scheme or Summation of treatment / prescription net amounts for the preceding Z records following each T record for the same patient (P record) ie F2 = (SUM Z2)
3	Claim Gross Amount	N..12	M	Gross amount of the claim for the patient reflected in the preceding P record, as calculated by the medical scheme or Summation of treatment / prescription gross amounts for the preceding Z records following each T record for the same patient (P record) ie F3 = (SUM Z3)
4	Total Claimed Amount	N..12	M	Claim gross amount less claim discount amount, as calculated by the medical scheme ie F4 = F3 F5 or Summation of treatment / prescription claimed amounts for the preceding Z records following each T record for the same patient (P record) ie F4 = (SUM Z11)

Claim Financial Record a b				SwitchClaim Response Format
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
5	Claim Discount Amount	N..12		Claim discount amount, as calculated by the medical scheme or Summation of treatment / prescription discount amounts for the preceding Z records following each T record for the same patient (P record) ie F5 = (SUM Z12)
6	Claim Overcharged Amount	N..12		Total amount overcharged by provider for this claim, as calculated by the medical scheme ie this amount is not payable by the patient so will not form part of the patient liable amount ie F6 = (SUM Z13)
7	Patient Levy Amount	N..12		Claim cumulative patient levy amount, as calculated by the medical scheme or Summation of treat,emt / prescription deductible / levy amounts for the preceding Z records following each T record for the same patient (P record) ie F7 = (SUM Z14)
8	Claim MMAP Surcharge	N..12		Cumulative MMAP surcharge for this claim, as calculated by the medical scheme. Summation of prescription MMAP surcharge amounts for the preceding Z records following each T record for the same patient (P record) ie F8 = (SUM Z15)
9	Claim Patient Co-Payment Amount	N..12		Cumulative patient co-patient amount for this claim for the patient reflected in the preceding P record, as calculated by the medical scheme or Summation of treatment / prescription co-payment amounts for the preceding Z records following each T record for the same patient (P record) ie F9 = (SUM Z16)
10	Claim Patient Liable Portion	N..12		Levy amount plus MMAP surcharge amount plus co-payment amount for the claim for the patient reflected in the preceding P record (ie F10 = F7 + F8 + F9) or Summation of treatment / prescription patient liable amounts for the preceding Z records following each T record for the same patient (P record) Ie F10 = (SUM Z17)

Claim Financial Record a b				SwitchClaim Response Format
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
11	Claim Medical Fund Liable Amount	N..12		Total claimed amount less patient liable amount for the claim for the patient reflected in the preceding P record ie F11 = F4 F10 or Summation of treatment / prescription medical fund liable amounts for the preceding Z records following each T record for the same patient (P record) Ie F11 = (SUM Z18)
12	Amount Authorized for Payment to Provider	N..12		Amount authorized by the medical scheme for payment to the provider for this treatment / prescription
13	Member Reimbursement Amount	N..12		Amount authorized by the medical scheme for reimbursement to the patient for this treatment / prescription

Footer (End of Message) Record a b

Footer (End of Message) Record a b				SwitchClaim Response Format
FIELD NO	**FIELD NAME**	**FORMAT**	**MAN**	**REMARKS**
1	Record Type	A..1	M	
2	Transmission Number	I..10	M	The original number submitted request records used to identify this claim/group of claims.
3	Number of Claims	I..3	M	Total number of responses in the batch.
4	Value of Claims	N..12	ALL	Value of claims (This is a control total of the Sum of the applicable Net Amounts in Z2 record, associated with "T" records).

Change History

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