healthOS

MEDICARE ONLINE, ECLIPSE AND DVA CLAIMING

Online Claiming User Manual

How to claim through Services Australia's Medicare Online, ECLIPSE and DVA web services in HealthOS: verifying patients, eligibility checks, bulk bill, patient, DVA, in-patient, in-hospital and overseas claims, the documents given to the claimant, reports and reconciliation.

Edition November 2026 · HealthOS, registered with Services Australia as HealthOS_Prod_MCOL_v1.0 · Support: support@healthos.net.au

About this manual

This manual is for the people who claim with HealthOS: reception, claims and billing staff, and practice managers. It covers checking a patient's Medicare, health fund, concession or veteran details; quoting a planned admission; lodging bulk bill, patient, DVA, in-patient medical, in-hospital and overseas visitor claims; what to give the patient; and how to check the next day that each claim was paid.

If you are new to claiming in HealthOS, read sections 2, 3 and 4 first. They take ten minutes and tell you where everything is, which claim to make, and what a normal day looks like. After that, go straight to the chapter for the job in front of you. Every claim chapter can be read on its own.

Software product	HealthOS (Services Australia product name **HealthOS_Prod_MCOL_v1.0**)
Vendor	HealthOS Pty Ltd, ABN 81 697 460 889
Manual version	3.0
Companion document	**HealthOS Installation and Authentication Guide**: setting up an organisation, PRODA, user accounts and sign-in, for administrators

How to find what you need

The PDF is fully searchable. Press **Ctrl+F** (**Cmd+F** on a Mac) and type what you are looking at: a button ("Lodge claim"), a message ("Vendor mode required"), a code shown on a claim ("9633"), or a document ("Lodgement Advice"). The reader jumps to every place it appears. You never need to read the contents to find a subject.

The bookmarks panel of your PDF reader lists every numbered heading and jumps to it. Each screenshot has a caption naming its screen, so a search for a screen's name finds its picture too. **Section 17 lists the messages and codes you may see, each with what it means and what to do.**

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SECTION 1

Support and contact details

For help with HealthOS, email **support@healthos.net.au**. If claiming has stopped altogether, say so in the subject line.

So that we can help quickly, tell us:

- your organisation and the screen you were on,
- what you expected and what happened, with the exact message,
- the **Transaction ID** shown on the claim or check (it looks like FSX00000f74ab4b93bb348f0).

Every check, claim and report shows its Transaction ID. Every call HealthOS makes to Services Australia is also listed with it on **Online Claiming → Transactions** (section 14.6).

HealthOS support is your one contact for claiming. HealthOS holds the connection to Medicare Online, ECLIPSE and DVA, so you don't need to contact Services Australia about claiming through HealthOS. We

take every claiming question, including an assessment you don't understand, and raise it with Services Australia ourselves when it needs them, quoting the Transaction ID. If Services Australia's systems are down, we tell you.

The only things your organisation keeps with Services Australia directly are its own registrations, which only you can hold: your organisation's PRODA account and B2B device (Appendix A.2), and your practitioners' Medicare provider numbers.

SECTION 2

Installing, accessing and finding your way around

2.1 Nothing to install

HealthOS runs in your web browser. HealthOS hosts it in Australia (Microsoft Azure, Australia East) and updates it centrally, so there is nothing to install or upgrade on your computer. HealthOS's servers talk to Services Australia, not your computer, so your site needs no firewall changes.

You need:

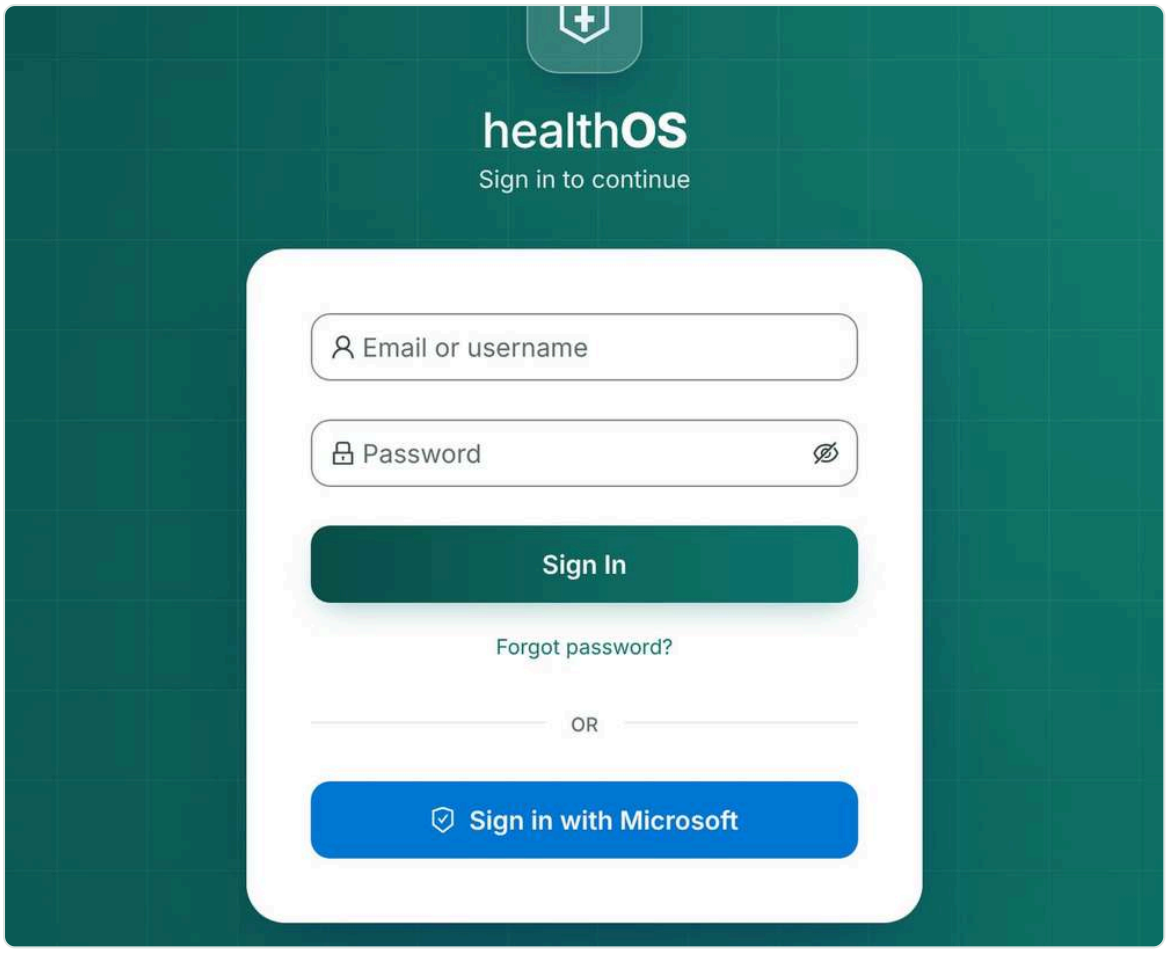
- **Microsoft Edge, Google Chrome, Mozilla Firefox or Apple Safari**, kept up to date (minimum versions are in the Installation and Authentication Guide).
- **Pop-ups allowed for your HealthOS address.** Claim documents such as the Statement of Claim and Benefit open in a new window for printing, and a blocked pop-up is the most common reason "nothing happens".
- **A printer**, for the documents the patient takes or signs.
- **Your organisation's HealthOS address and a HealthOS account.** Your administrator gives you both. Your account needs a role that includes billing and claiming (for example Finance Officer).

An administrator sets up claiming once for the whole organisation (Appendix A, and the Installation and Authentication Guide). Until that is done, every claiming card shows **Vendor mode required**.

2.2 Signing in

1. Open your organisation's HealthOS address in the browser.
2. Enter your **Username** and **Password**, or choose your organisation's single sign-on button (for example Microsoft) if one is shown.
3. If HealthOS says your organisation requires multi-factor authentication, use the single sign-on button instead of your password.

HealthOS signs you out after a period without activity (15 minutes unless your organisation has changed it). Anything typed but not saved is lost, so create the draft or lodge the claim before you leave the desk.



The HealthOS sign-in page. Enter your email or username and password, or choose **Sign in with Microsoft** where your organisation uses single sign-on.

2.3 Where claiming lives

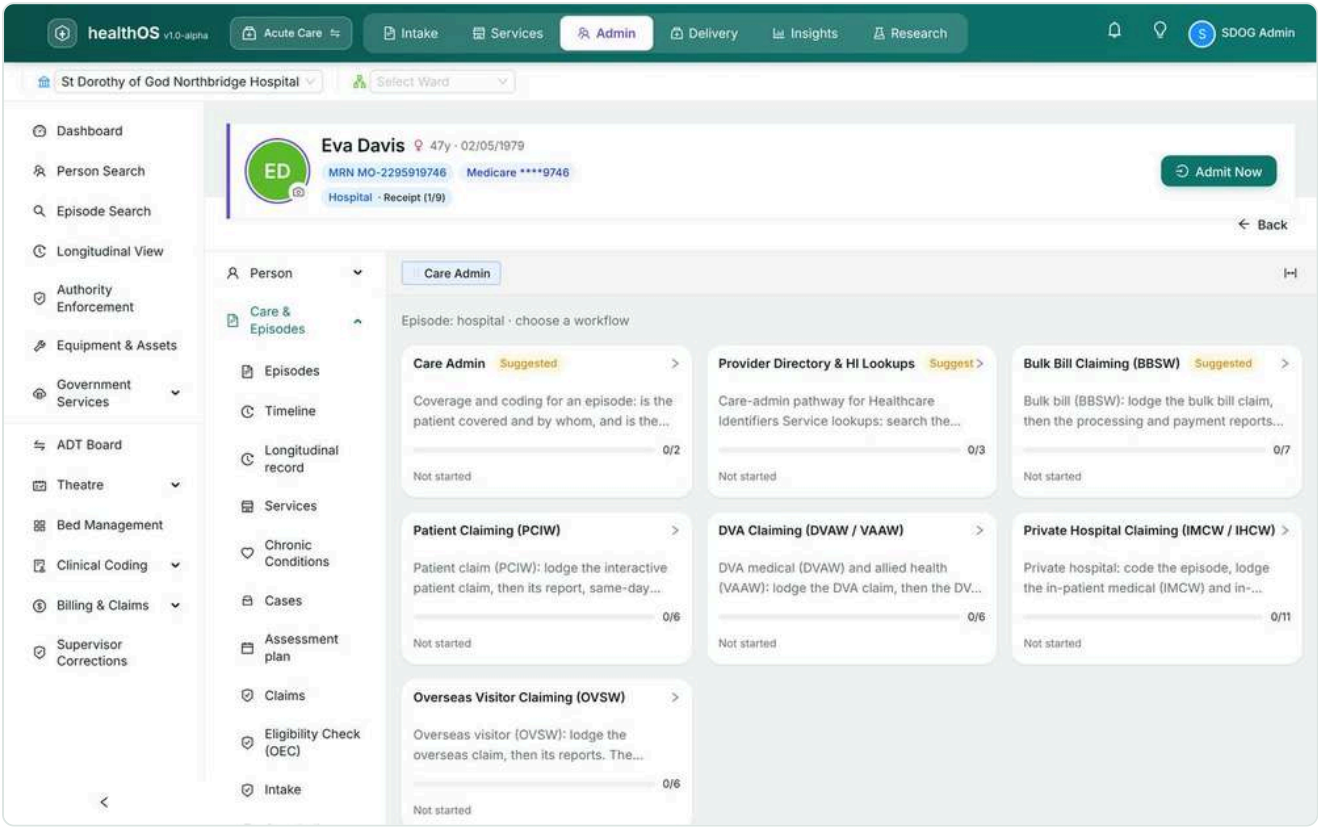
You claim in two places: **on the patient's chart**, for one patient at a time, and in **Online Claiming**, for work across all patients.

TO…	GO TO
Check a patient's Medicare, fund, concession or DVA details	Patient chart → **Intake** → **System: Intake — Coverage & Eligibility**
Quote a planned admission before it happens	**Intake → Referrals** → the referral → **Eligibility & Financial Consent** (or the chart's **Eligibility Check (OEC)** section)
Make, lodge, correct or delete a claim for a patient	Patient chart → **Care Admin** → the claiming pathway for that claim type (table below)
See what is waiting to be claimed, lodge batches, check reports and payments	**PAS → Billing & Claims → Online Claiming (Medicare, DVA & Health Funds)**

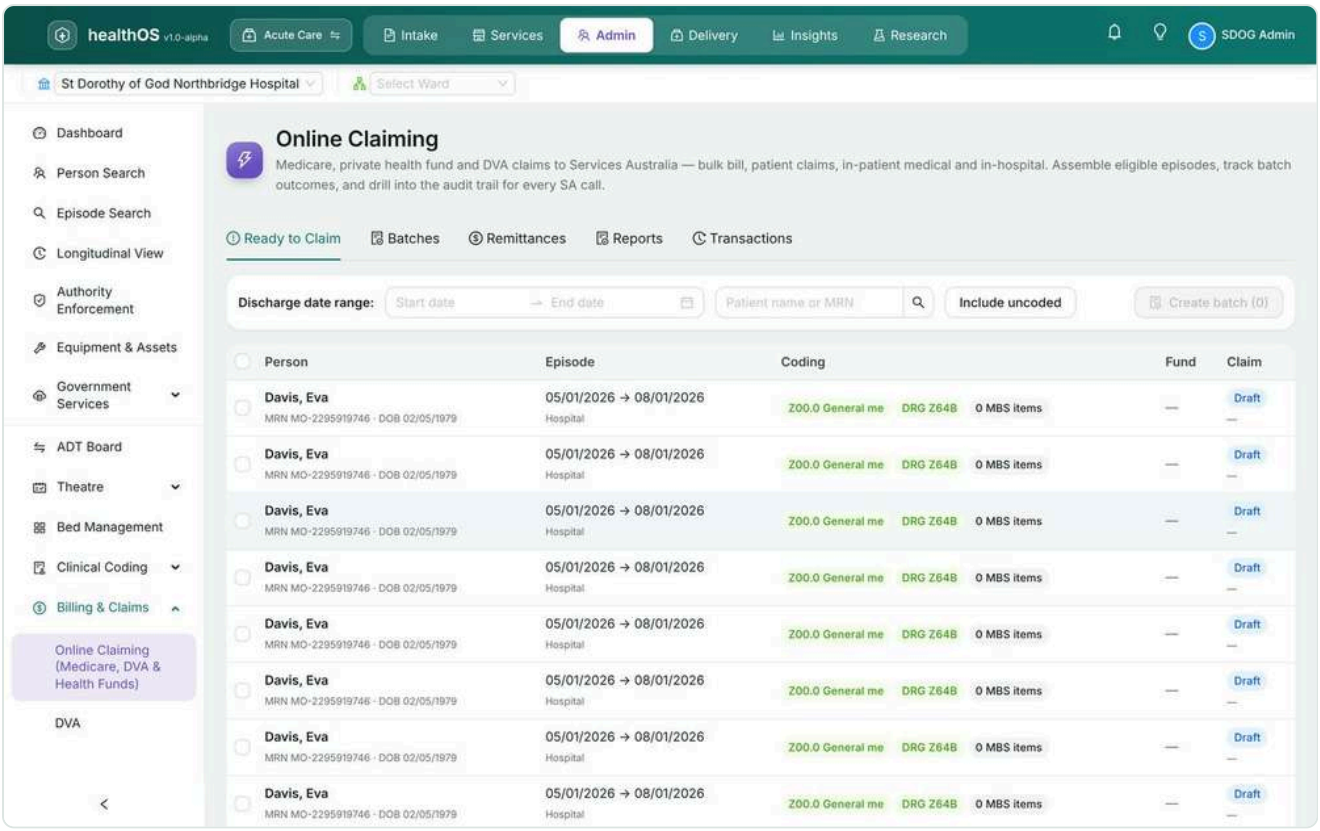
The claiming pathways on the chart's **Care Admin** section:

PATHWAY	USED FOR	STAGES
System: Bulk Bill Claiming (BBSW)	Bulk bill claims	Claim → Reports & Reconciliation
System: Patient Claiming (PCIW)	Patient claims, same-day delete	Claim → Reports & Reconciliation

PATHWAY	USED FOR	STAGES
System: DVA Claiming (DVAW / VAAW)	DVA medical, allied health and community nursing claims	Claim → Reports & Reconciliation
System: Private Hospital Claiming (IMCW / IHCW)	In-patient medical and in-hospital claims	Coding & Grouping → Claim → Reports & Reconciliation
System: Overseas Visitor Claiming (OVSW)	Overseas visitor claims	Claim → Reports & Reconciliation



A patient's chart, **Care & Episodes → Care Admin**: each claiming pathway is a card (Bulk Bill, Patient, DVA, Private Hospital and Overseas Visitor Claiming) showing how far it has got.



PAS → Billing & Claims → Online Claiming: the Ready to Claim, Batches, Remittances, Reports and Transactions tabs, for work across every patient.

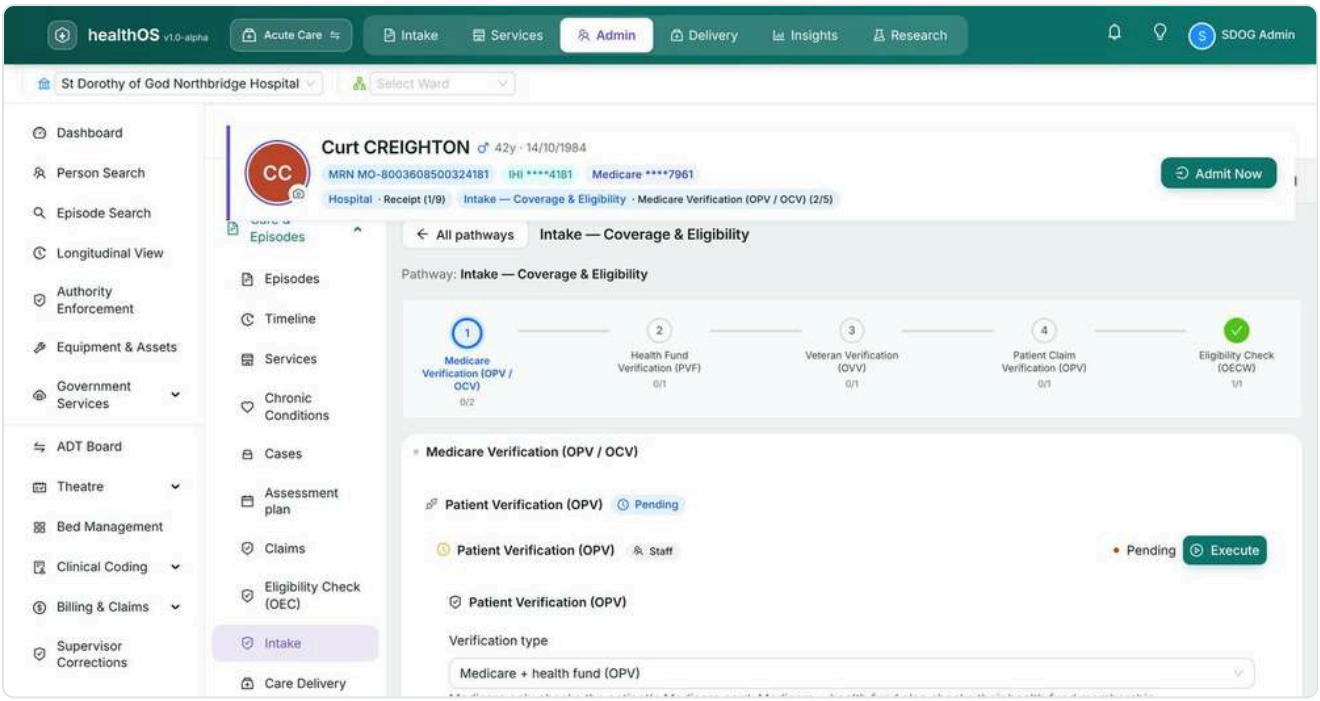
2.4 How a pathway works

A pathway is a row of **stages** across the top (click one to open it). Each stage holds **cards** that each do one job, such as "Draft Bulk Bill Claim" or "Submit Bulk Bill Claim (BBSW)".

Every claim follows the same pattern:

1. **Draft** the claim on its Draft card and choose **Create draft claim**. The draft is saved; nothing has been sent yet.
2. **Lodge** it on its Submit card with **Lodge claim**, then confirm with **Lodge**. This sends it to Services Australia.
3. Read the **answer**, which appears inside the same card, and print what the patient needs.

Details already on the patient's record (Medicare card, DVA file number, health fund) fill in by themselves. Check them against the card in front of you.



The Coverage & Eligibility pathway opened on the patient's chart: the stages across the top (Medicare Verification, Health Fund Verification, Veteran Verification, Patient Claim Verification, Eligibility Check) and the first stage's card below.

2.5 Fitting the pathways to your practice

The claiming pathways HealthOS supplies are a starting point, not a fixed process. Your administrator can change them in the **pathway builder** to match the way your practice works. For example, you can:

- add a stage of your own, such as "Front desk check-in" before **Claim**, or "Follow up" after **Reports & Reconciliation**
- add cards to a stage, such as a letter or email to the patient, a form for staff to fill in, or a check from another pathway
- reorder stages and cards, rename them, and make a card **required** before the patient moves on
- make a stage wait for another stage to be finished first (**Requires**)
- put a card on a team's worklist, so it appears in their queue

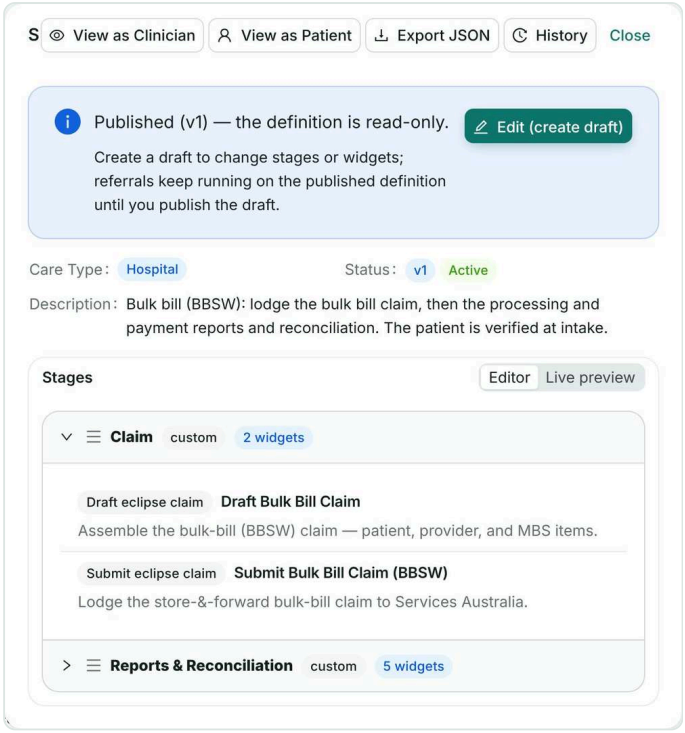
What a claiming card sends to Services Australia stays the same, wherever you put it. The builder changes the order and the work around the claim, not the claim itself. Keep each claim type's Draft and Submit cards on its pathway, or your staff will have nowhere to lodge that claim.

Only an administrator with permission to change settings can edit pathways. Other staff see the pathways as published.

Open the pathway builder

1. Sign in to the admin portal and go to **Care Admin → Pathways**.
2. Select the pathway, for example **System: Bulk Bill Claiming (BBSW)**.

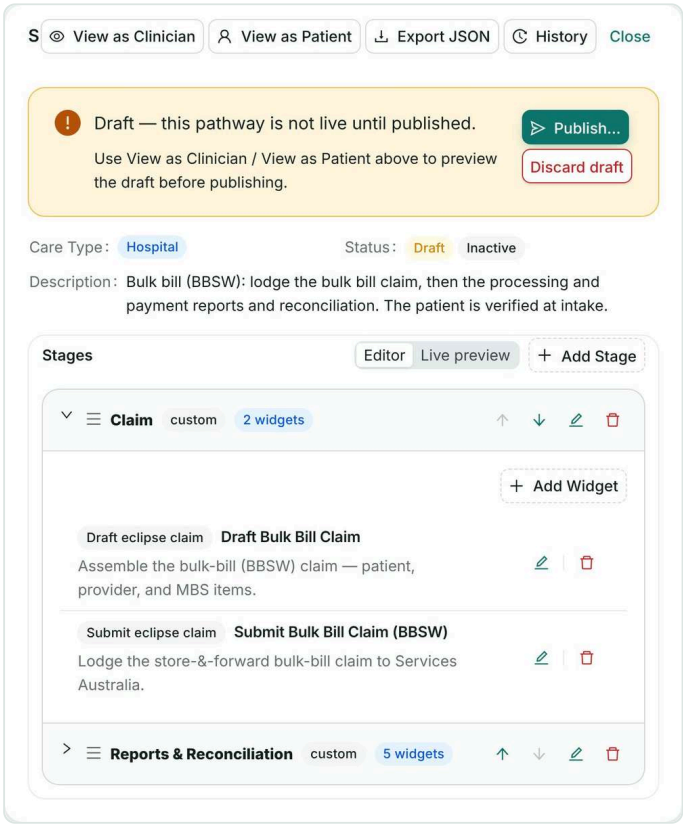
The pathway's stages and cards are shown on the right. A published pathway is read-only, so changing it never disturbs a patient part-way through a claim.



Care Admin → Pathways in the admin portal with the Bulk Bill Claiming pathway selected: the **Claim** stage holds its Draft and Submit cards, and **Reports & Reconciliation** holds five more. The published pathway is read-only until you create a draft.

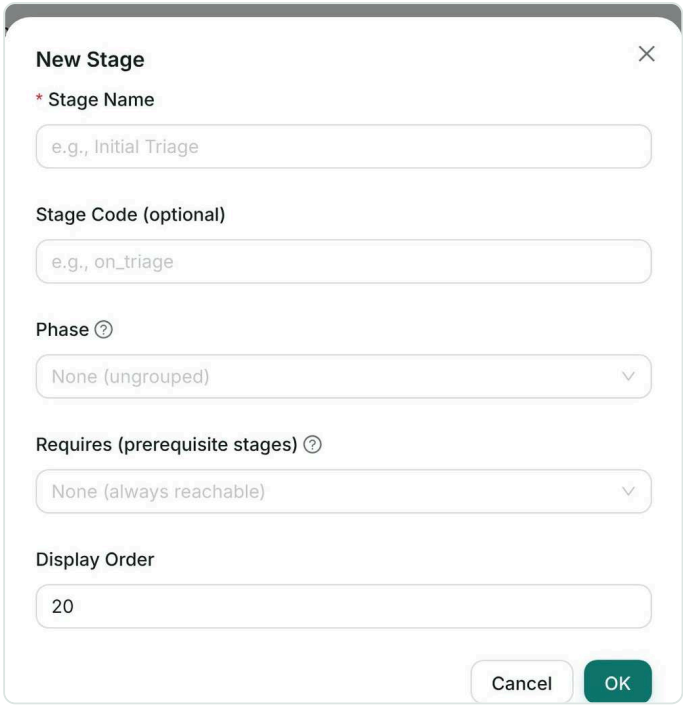
Make your changes on a draft

1. Choose **Edit (create draft)**. HealthOS makes your organisation's own copy of the pathway to work on. Everyone keeps using the published pathway until you publish. The arrows beside a stage or card move it up or down, the pencil edits it, and the bin removes it.



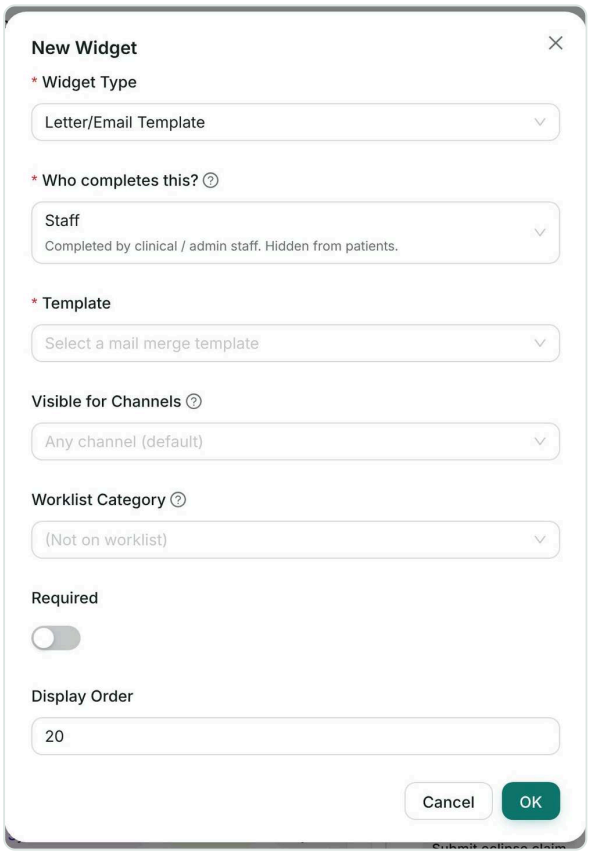
A draft of the Bulk Bill Claiming pathway: **Add Stage**, **Add Widget**, the arrows to reorder, and **Publish...** and **Discard draft** at the top. The draft is not live until it is published.

2. To add a stage, choose **Add Stage**. Give it a name, choose its place in the order (**Display Order**), and choose any stage it **Requires** to be finished first.



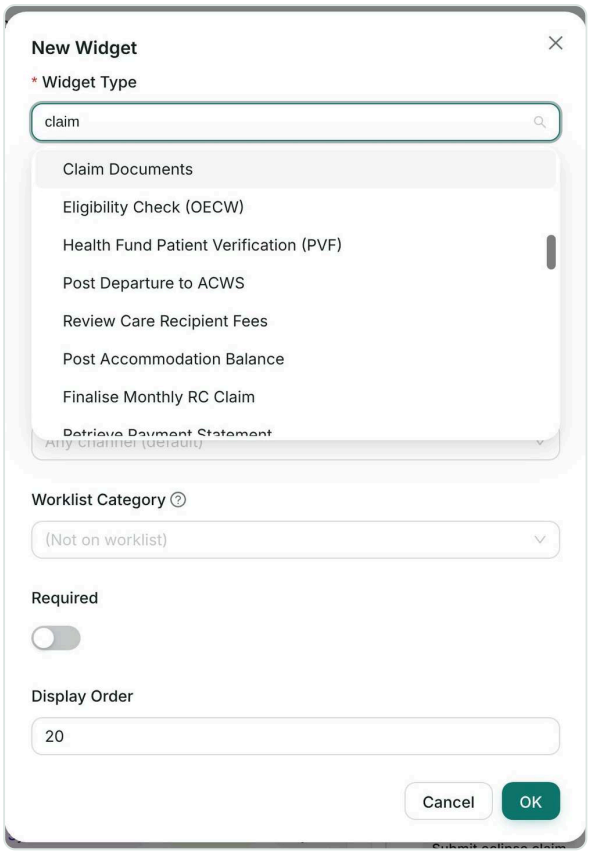
Add Stage: the stage's name, its phase, the stages it requires first, and its place in the order.

3. To add a card to a stage, open the stage and choose **Add Widget**. Choose the **Widget Type**, who completes it (staff or the patient), and whether it is **Required**.



Add Widget: the widget type, who completes it, and whether it is required.

4. The **Widget Type** list holds every card HealthOS has, including the claiming, eligibility and verification cards. Type to search it.



The widget types, searched for "claim".

5. Choose **View as Clinician** or **View as Patient** to check the draft before it goes live.
6. Choose **Publish...** and say briefly what changed. The draft becomes the live pathway, as a new version. **Discard draft** throws the draft away instead.

Go back to an earlier version

Every publish is kept. Choose **History** on the pathway to see each version and what changed, and restore one into a draft. Publish that draft to put the earlier version back. **Export JSON** saves a copy of a pathway, and **Import** on the Pathways page loads one, for example to copy a pathway between sites.

If a change to a pathway stops your staff from finding a claim card, contact HealthOS support (section 1).

SECTION 3

Which claim do I need?

Find the patient's situation in the left column.

THE PATIENT...	MAKE A	WHAT HAPPENS	SEE
is bulk billed: pays nothing, and you are paid by Medicare	**Bulk bill claim**	Patient signs the assignment of benefit (DB4). Medicare assesses overnight and pays you	7
has paid all or part of the account, or not yet paid, and wants their Medicare rebate now	**Patient claim**	Lodged while the patient is with you; Medicare answers within seconds; patient takes a Statement of Claim and Benefit	8

THE PATIENT…	MAKE A	WHAT HAPPENS	SEE
is a veteran with a DVA Gold, White or Orange card	**DVA claim**	Veteran signs the DVA voucher; DVA assesses overnight and pays you	9
is a private in-patient, for the doctors' medical services	**In-patient medical claim (IMC)**	Sent to the health fund and Medicare together through ECLIPSE	10
is a private in-patient, for the hospital's own charges (accommodation, theatre, prostheses)	**In-hospital claim (IHC)**	Sent to the health fund through ECLIPSE	11
is an overseas visitor covered by an overseas insurer	**Overseas visitor claim (OVS)**	Sent to the visitor's insurer through ECLIPSE	12
is booked for an admission or procedure and wants to know what they will get back	**Eligibility check** (a quote, not a claim)	Medicare and/or the fund say what each item would pay; patient signs informed financial consent	6

Before any claim, **check the patient's details** (section 5). A claim with an out-of-date Medicare card is refused.

HealthOS does not report immunisations to the Australian Immunisation Register (AIR). Use your existing AIR channel for those.

3.1 What the answers mean

Services Australia answer in codes. HealthOS shows the code with its meaning. The ones you will see on a claim are:

YOU SEE	IT MEANS	WHAT YOU DO
MEDICARE_ASSESSED (or "assessed")	Medicare has worked out the benefit	Print the **Statement of Claim and Benefit** for the patient
MEDICARE_PENDABLE	Medicare cannot decide automatically and needs a person to look at it	Give the **Lodgement Advice**, then **Resubmit to pend** (section 8.4)
MEDICARE_PENDED	Queued for a Medicare officer, who will assess it later	Nothing more today; the outcome comes in the reports
Received / accepted (bulk bill, DVA, ECLIPSE)	Received, to be assessed overnight or by the fund	Nothing; the outcome comes in the next day's reports (section 14)
A red box, for example Lodgement failed — Services Australia: 9202 — …	Refused. Nothing was claimed	Read the reason, correct the claim and lodge again (sections 15 and 17)
A service line marked reduced or rejected, with a Reason	That service was paid less, or not paid	Check the reason; correct and re-lodge that service if it was a mistake (section 15.3)

SECTION 4

A typical day

When the patient arrives

1. Open the patient's chart and check their Medicare card, and their health fund, concession or DVA card if they have one (section 5). Accept any update Services Australia give, once the patient confirms it.

While the patient is with you

2. For a **patient claim**, draft and lodge it, then print the **Statement of Claim and Benefit** (or the **Lodgement Advice**) and give it to the patient (section 8).
3. For a **bulk bill** or **DVA** claim, have the patient sign the DB4 or the DVA voucher, and create the draft (sections 7 and 9). You can lodge it now, or later in a batch.
4. For a **planned admission**, run the eligibility check and give the patient the OEC report with the informed financial consent (section 6).

At the end of the day

5. Open **PAS → Billing & Claims → Online Claiming**. On **Ready to Claim**, check nothing is waiting that should have gone today, and lodge any bulk bill and DVA drafts, singly or as a batch (section 7.4).
6. A patient claim lodged by mistake can be withdrawn only **today**, with **Same Day Delete** (section 8.6).

The next morning

7. HealthOS has already collected overnight reports and health fund remittances. Open **Online Claiming → Reports** and look for services that were reduced or rejected (section 14.5).
8. Correct and re-lodge anything rejected by mistake (section 15).
9. Match payments to the bank statement using **Remittances** and the payment reports (section 14.7).

SECTION 5

Checking the patient's details (verification)

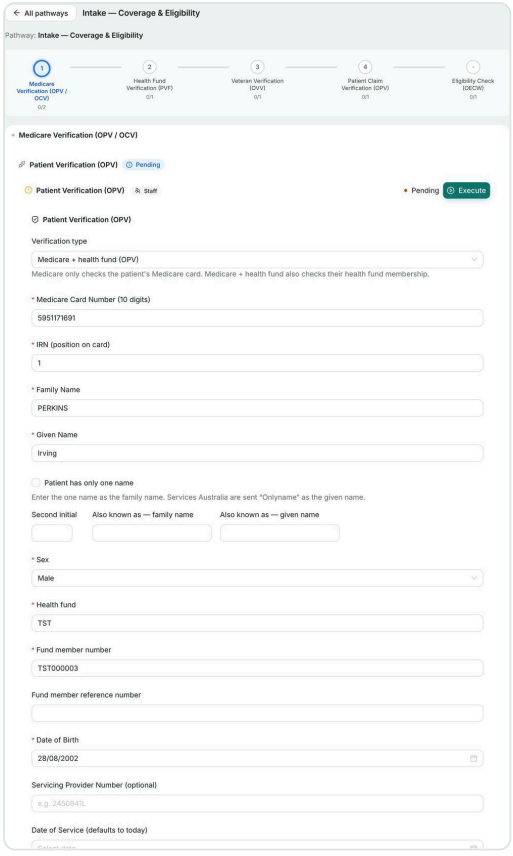
Checking confirms with Services Australia that the patient's Medicare card, health fund membership, concession card or DVA file number is current. **Do it at every admission or first visit**: a claim carrying a card that has since been reissued is refused.

Where: patient chart → **Intake** → **System: Intake — Coverage & Eligibility**.

TO CHECK	STAGE	CARD
Medicare card	Medicare Verification (OPV / OCV)	Patient Verification (OPV), type **Medicare only (PVM)**
Medicare card and health fund together	Medicare Verification (OPV / OCV)	Patient Verification (OPV), type **Medicare + health fund (OPV)**
Health fund only	Health Fund Verification (PVF)	Health Fund Patient Verification (PVF)

TO CHECK	STAGE	CARD
Concession card	Medicare Verification (OPV / OCV)	Concession Verification (OCV)
DVA card	Veteran Verification (OVV)	Veteran Verification (OVV)

The patient's details fill in from their record. **Check them against the card the patient shows you** before you run the check.



> The **Intake — Coverage & Eligibility** pathway on the patient's Intake hub: one stage each for Medicare, health fund, veteran and patient claim verification and the eligibility check. The Patient Verification (OPV) form is filled in from the patient's record.

5.1 Check a Medicare card

1. In **Patient Verification (OPV)**, set **Verification type** to **Medicare only (PVM)**.
2. Check **Medicare Card Number (10 digits)**, **IRN (position on card)**, **Family Name**, **Given Name**, **Sex** and **Date of Birth**.
3. Optionally enter the **Servicing Provider Number** and **Date of Service** (today unless you change it).
4. Choose **Run PVM (Medicare only)**.

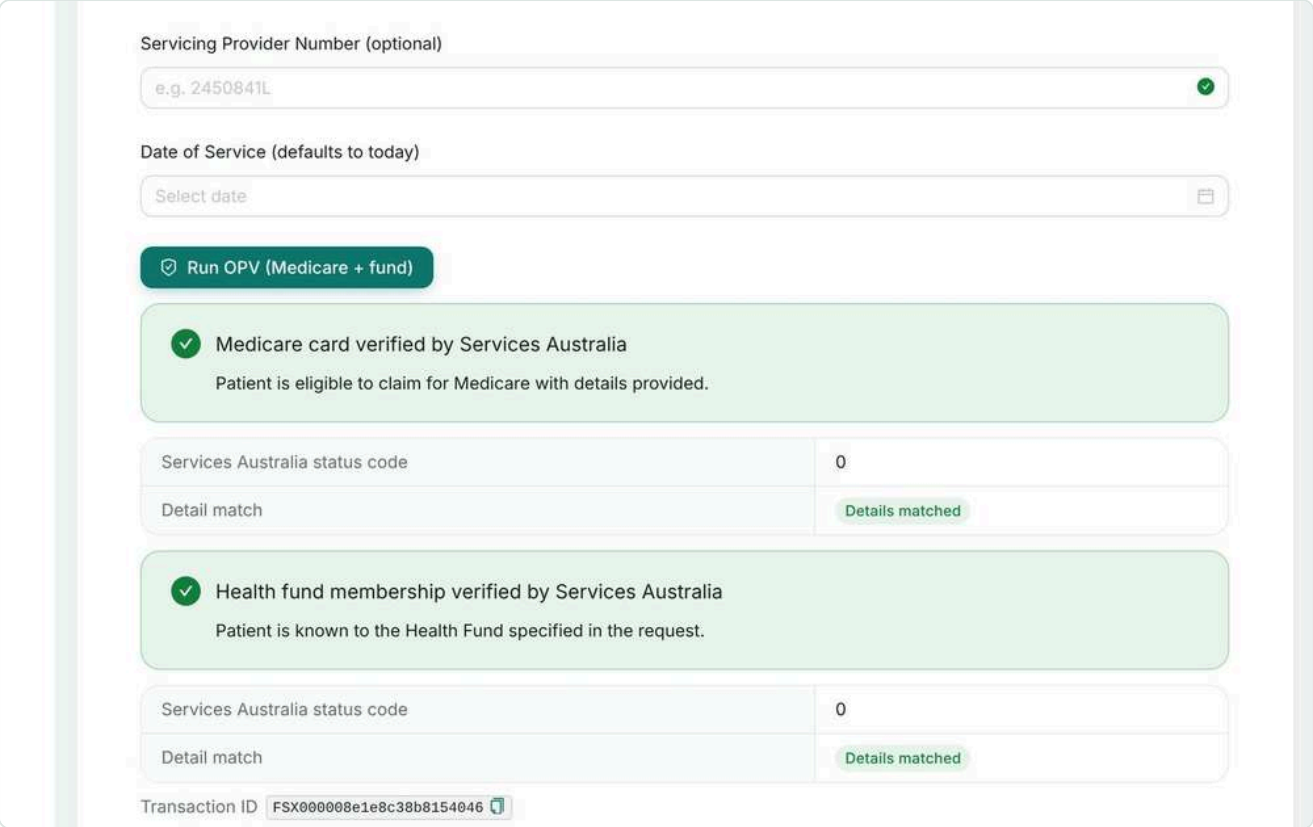
What you'll see: the outcome in words, for example "Medicare card verified by Services Australia", with the status code, whether the details matched, and the Transaction ID. If Services Australia hold different details, see 5.4.

5.2 Check a Medicare card and health fund together

1. Set **Verification type** to **Medicare + health fund (OPV)**.

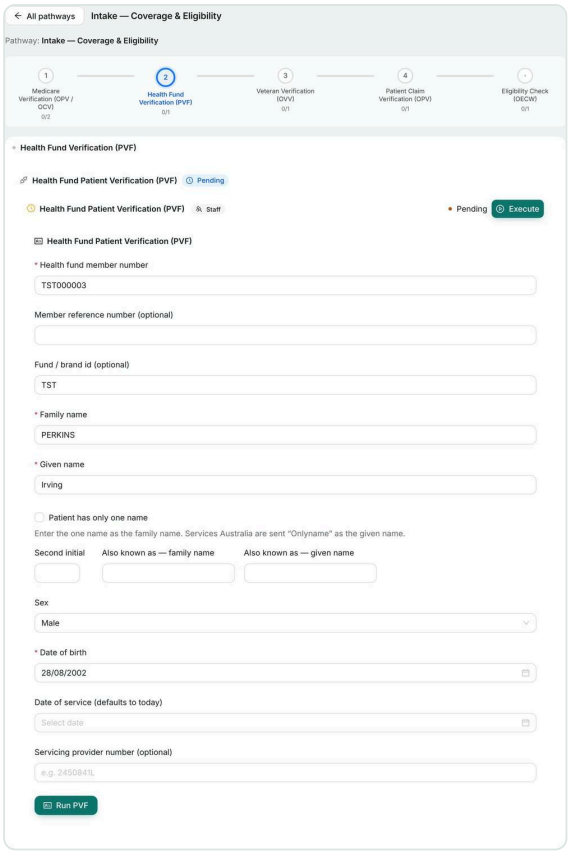
2. Check the Medicare details as in 5.1, and enter the **Health fund**, **Fund member number** and **Fund member reference number**.
3. Choose **Run OPV (Medicare + fund)**.

What you'll see: a Medicare result and a fund result, side by side. Either can pass while the other fails.



Patient Verification (OPV) result: both the Medicare card and the health fund membership verified, with the Services Australia status code, detail match and Transaction ID.

To check the health fund on its own, use the **Health Fund Verification (PVF)** stage. Enter the **Health fund member number**, the **Member reference number** and **Fund / brand id** if known, and the name, sex and date of birth, then choose **Run PVF**.

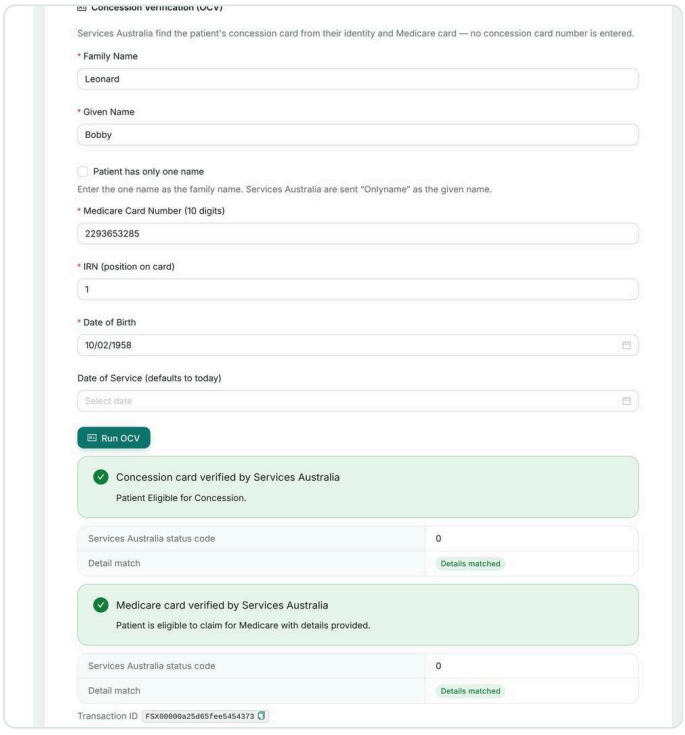


Health Fund Verification (PVF): the health fund member number, the fund (brand) id and the patient's details, filled in from the record, then **Run PVF**.

5.3 Check a concession card or DVA card

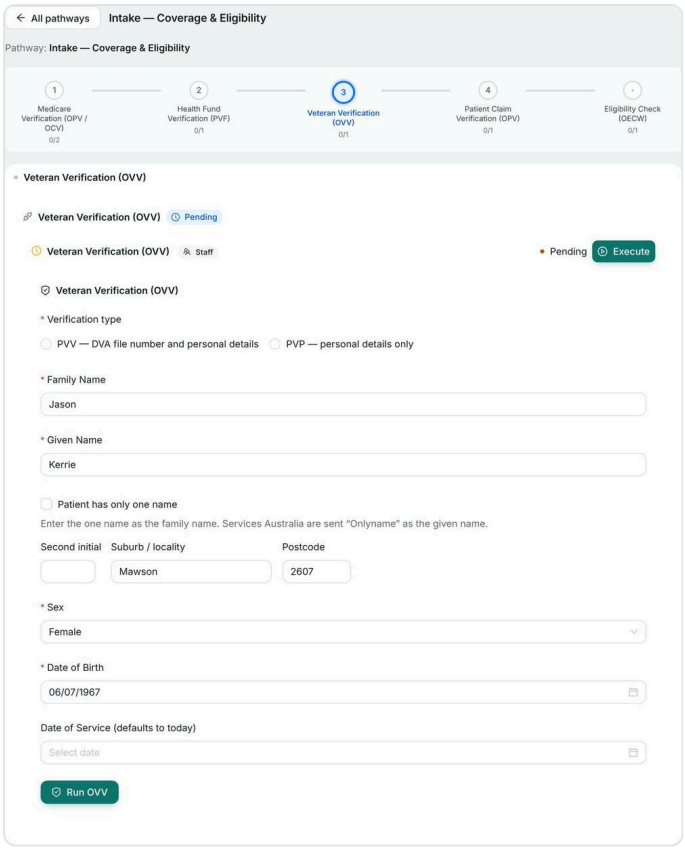
Concession card

1. In **Concession Verification (OCV)**, choose the **Card Type** (for example CSHC — Commonwealth Seniors Health Card).
2. Enter the **Card Number**, name, Medicare card number and IRN, and date of birth.
3. Choose **Run OCV**. The result says whether the concession card and the Medicare card are each verified ("Patient Eligible for Concession").



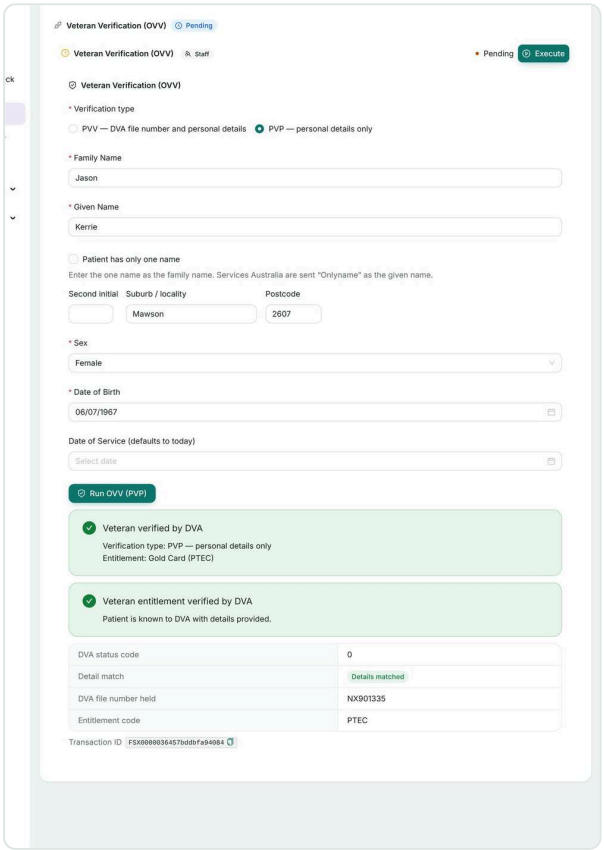
Concession Verification (OCV) result: the concession card and the Medicare card each verified, with their status codes.

DVA card



Veteran Verification (OVV) before it is run: the verification type (PVV, with the DVA file number, or PVP, personal details only), the veteran's details and **Run OVV**.

1. On the **Veteran Verification (OVV)** stage, enter the **DVA File Number**, family and given name and date of birth (suburb, postcode and sex are optional).
2. Choose **Run OVV**. The result shows whether the veteran is verified and their card type (Gold, White or Orange).

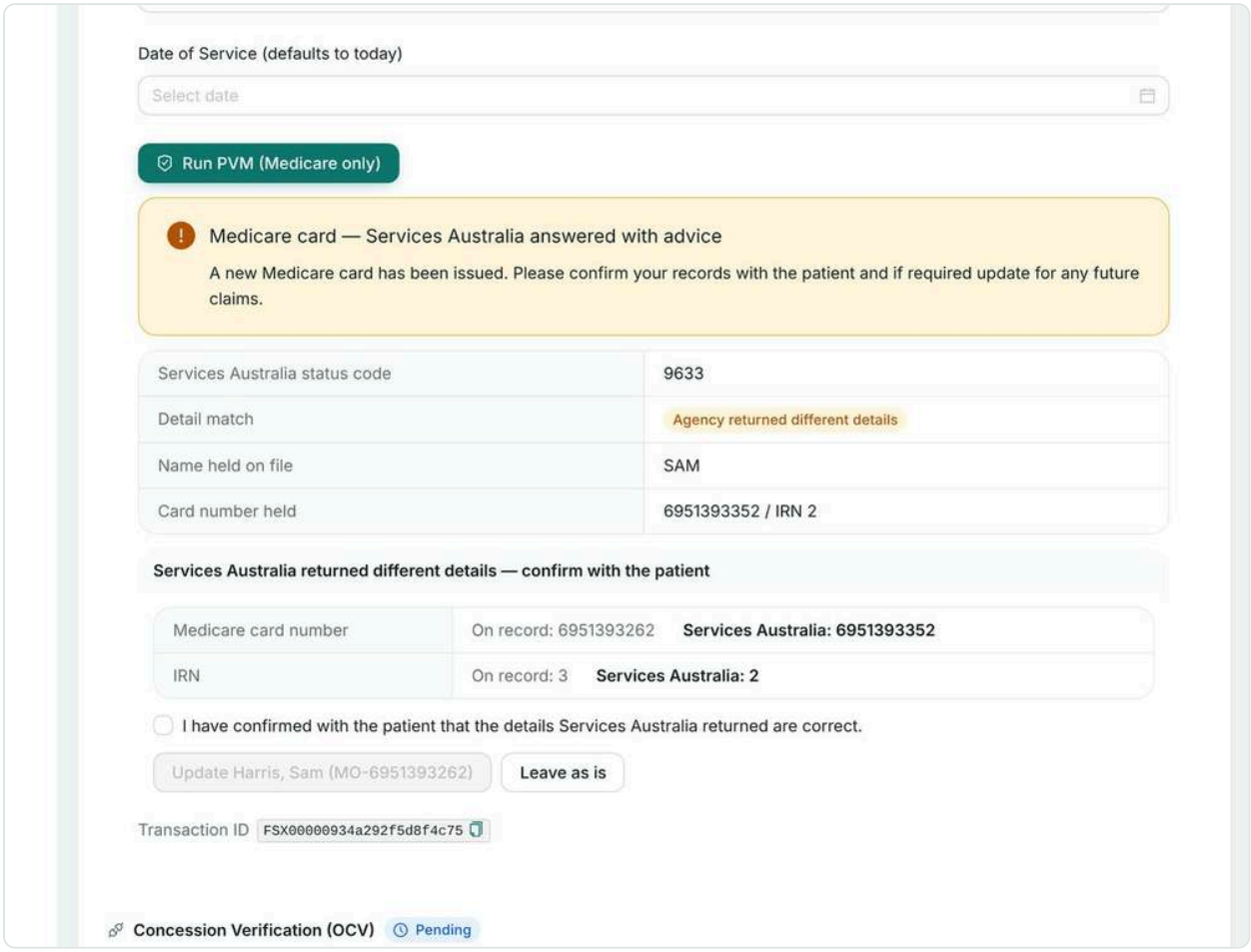


Veteran Verification (OVV): the DVA file number check and its outcome.

5.4 When Services Australia hold different details

Sometimes the check passes with advice. For example, **9633 "A new Medicare card has been issued"** means the card on file has been replaced. The card then shows the details on your record beside the details Services Australia hold.

1. Ask the patient to confirm the new details (usually by showing their new card).
2. If they are right, tick **"I have confirmed with the patient that the details Services Australia returned are correct"** and choose **Update**. The patient's record is corrected.
3. If they are not right, choose **Leave as is**. Nothing on the record changes until you confirm.



Services Australia answered with advice (status code 9633, a new Medicare card has been issued): the card number and IRN on record beside the ones Services Australia returned, with the confirm, Update and Leave as is controls.

The date of the last successful check is shown on the patient's **Demographics** (Funding → "Medicare last verified").

SECTION 6

Quoting a planned admission (eligibility check)

An eligibility check asks Medicare and/or the patient's health fund **what they would pay** for a planned admission or treatment, before it happens. You give the result to the patient with their informed financial consent. **It is a quote only. It does not claim anything**, and you still lodge the claim afterwards.

CHOOSE	WHEN THE PATIENT…
ECM — Medicare only	has Medicare but no health fund cover for this
ECF — Health fund only	wants the fund's answer only
OEC — Medicare & health fund	has Medicare and private health insurance (the usual case for a private admission)
ECO — Overseas	is an overseas visitor with an overseas insurer

Before you start: check the patient's Medicare and fund details (section 5). Have the admission details to hand: principal provider, hospital Facility ID, admission date and length of stay, and the MBS items (and any prosthesis codes) planned.

6.1 Run the check from the referral

This is the usual place, because the quote sits beside the patient's financial consent.

1. Open **Intake → Referrals** and the patient's referral.
2. On its pathway, open the **Eligibility & Financial Consent** stage.
3. In **Eligibility Check (OECW)**, choose the **Check** (ECM, ECF, OEC or ECO). Medicare and fund details fill in from the record.
4. Enter the planned admission: principal provider, **Facility ID**, admission date, same day or length of stay, and the presenting illness.
5. Enter the services: MBS items in **MBS services**, and any prosthesis or miscellaneous code in **Fund prosthesis / miscellaneous lines** with its quantity and rate.
6. Choose **Check eligibility**.

What you'll see: each item with what Medicare and the fund would pay.

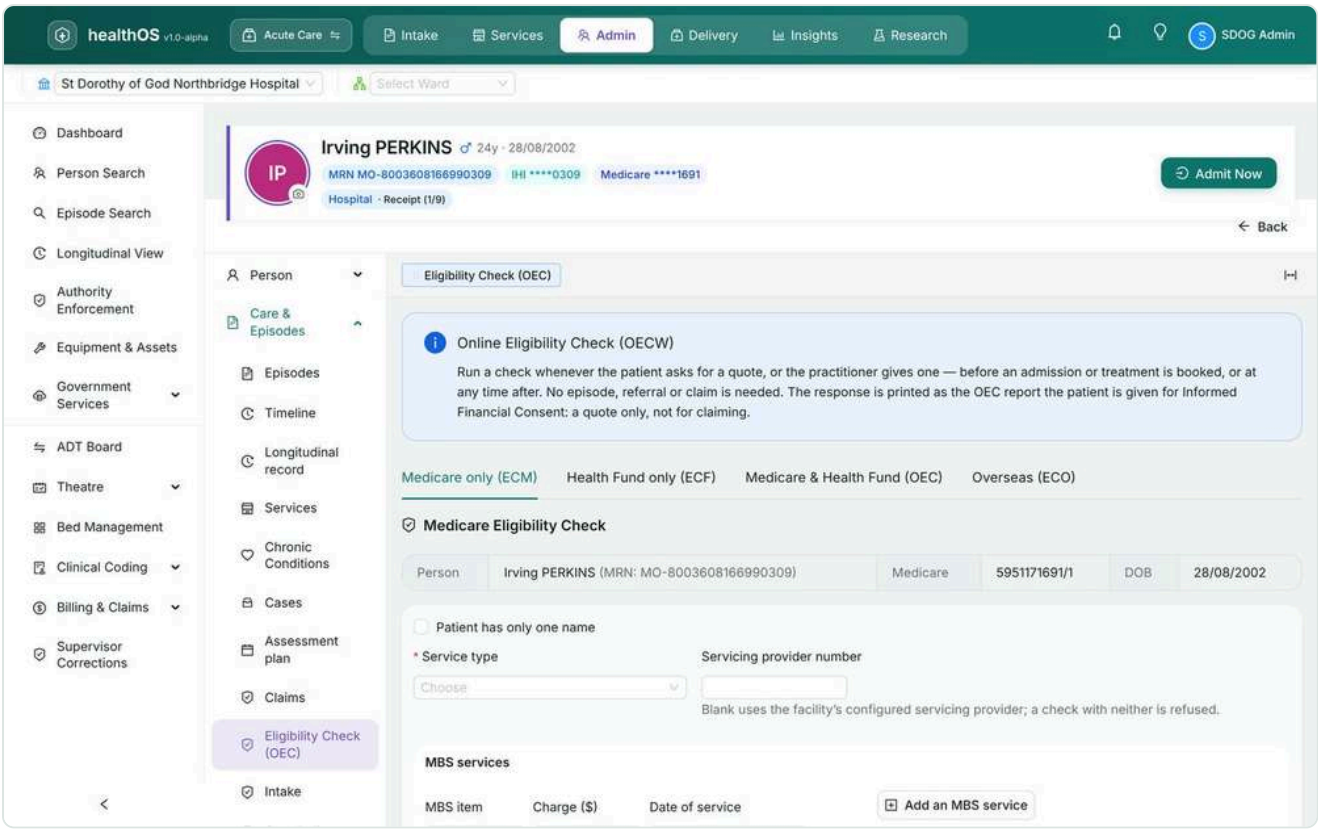
What to do next:

- Choose **OEC report** and give the printed report to the patient (section 13.6).
- Record the patient's consent in **Informed Financial Consent** on the same stage.
- When you later draft the claim, the Draft card offers **Start from it**, which fills the claim from this check.

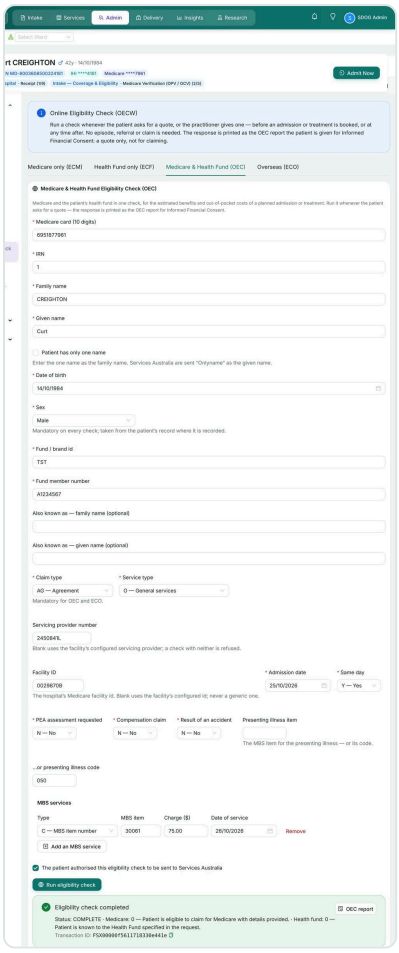
6.2 Run the check from the patient's chart

The same check is available in two other places when there is no referral:

- Patient chart → **Intake** → **System: Intake — Coverage & Eligibility** → **Eligibility Check (OECW)** stage, alongside the patient's verifications.
- Patient chart → **Eligibility Check (OEC)** section. Choose the tab (**Medicare only (ECM)**, **Health Fund only (ECF)**, **Medicare & Health Fund (OEC)** or **Overseas (ECO)**), complete the form (Medicare card, IRN, name, date of birth, provider number, fund/brand id, member number, MBS item and optional charge) and choose **Run eligibility check**. **OEC report** opens the printable report.



The **Eligibility Check (OEC)** tab on the patient record: the patient and episode, a tab for each kind of check, and the services to check.



Medicare & Health Fund Eligibility Check (OEC) completed: Medicare and the health fund outcomes and the Transaction ID, with the OEC report button.

SECTION 7

Bulk bill claims

Use a bulk bill claim when the patient pays nothing and Medicare pays you. The patient **assigns** their Medicare benefit to the provider by signing a DB4 form. Medicare receives the claim straight away but **assesses it overnight**, so you learn the outcome the next morning.

Where: patient chart → **Care Admin** → **System: Bulk Bill Claiming (BBSW)**.

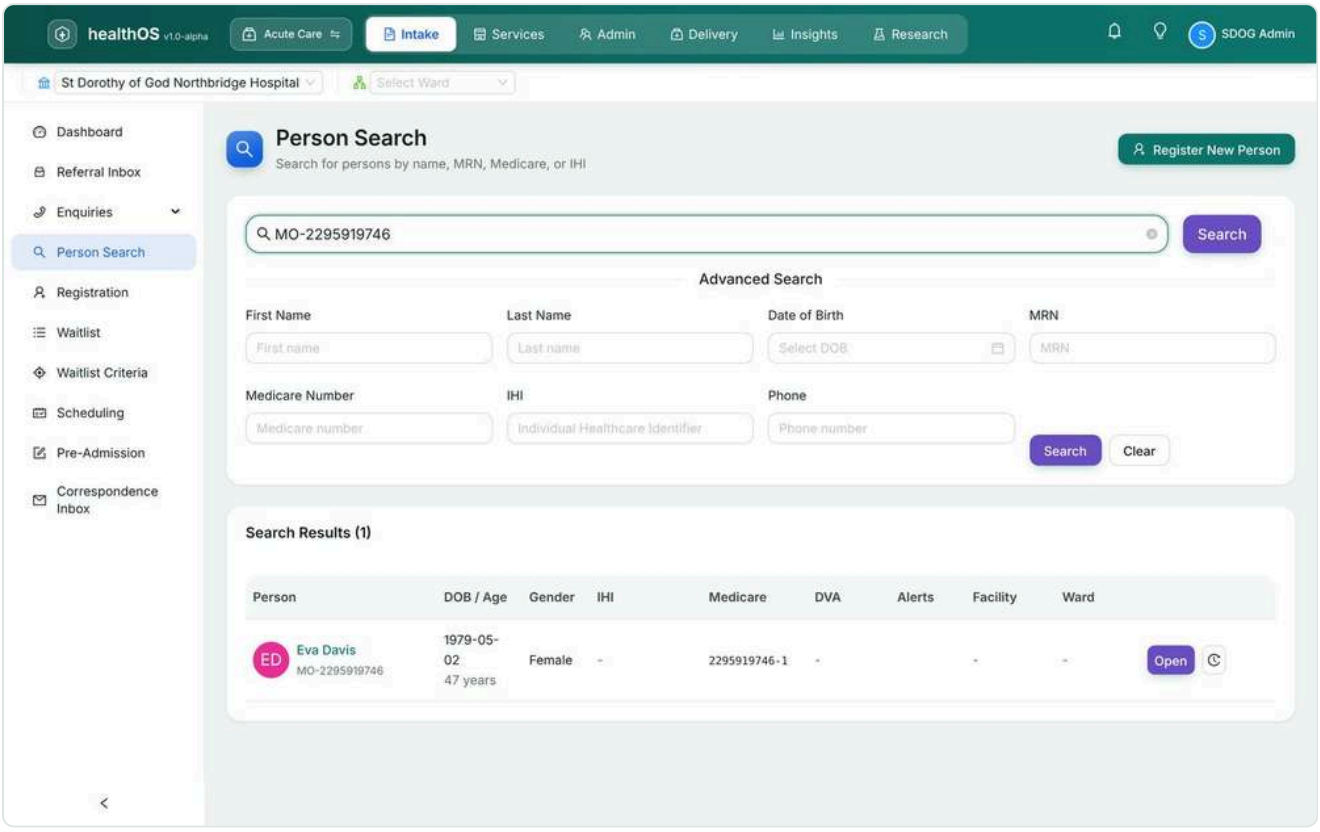
Before you start:

- The patient's Medicare card has been checked (section 5).
- You know the servicing provider's number, the service date, the MBS items and your charge.
- For a referred (specialist) service, you have the referral: who referred, the date and the period.

Worked example: a bulk bill claim from start to finish

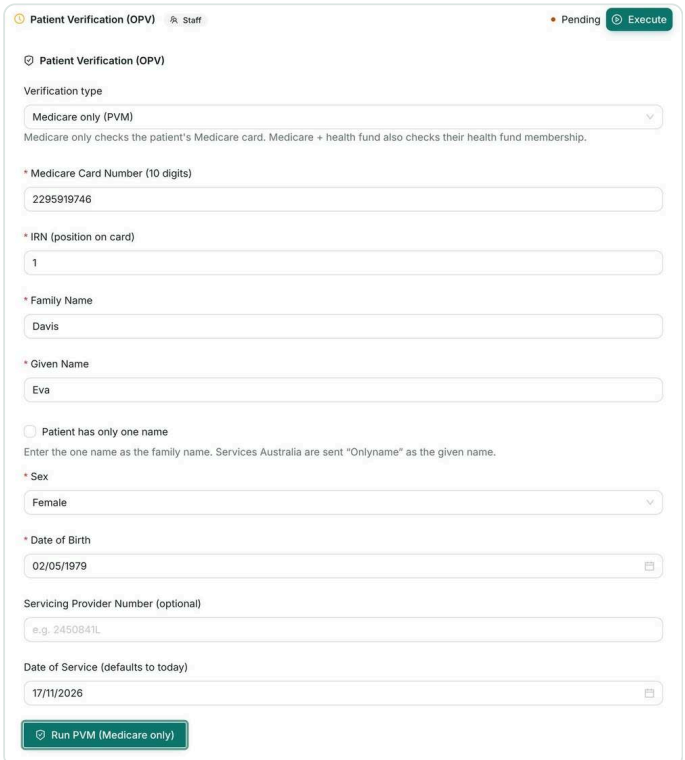
This example follows one patient, Eva Davis, through a specialist bulk bill claim. It was lodged in Services Australia's test environment on 17 November 2026, with Services Australia's own test patients and providers. The numbered sections after it explain each step and its options.

1. **Find the patient.** Open **Person Search**, search by MRN, Medicare number or name, and open the patient's chart.



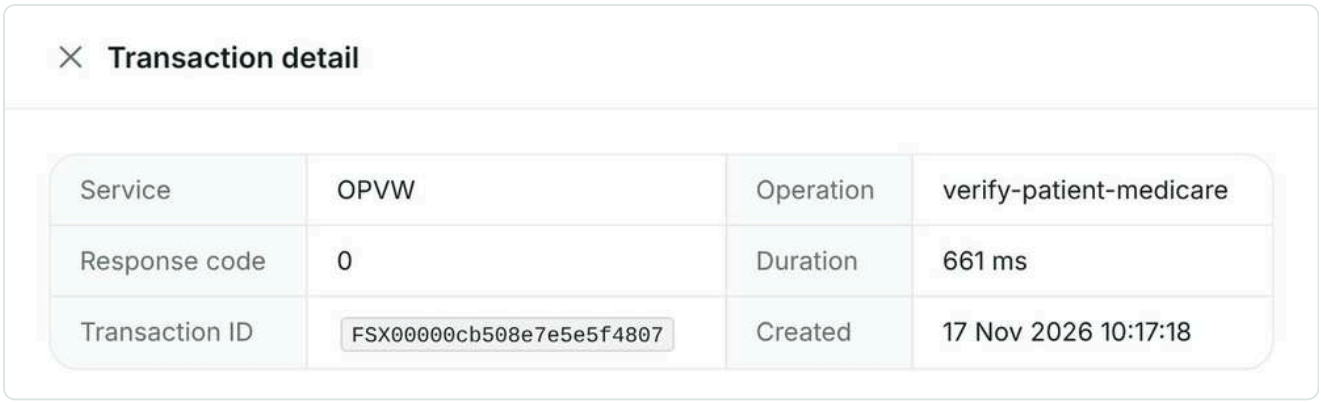
Person Search with the patient found by her MRN.

2. **Check the Medicare card.** On the chart, open **Intake → Intake — Coverage & Eligibility** at the **Medicare Verification** stage. The **Patient Verification (OPV)** card is filled in from the patient's record. Choose **Medicare only (PVM)** and **Run PVM** (section 5.1).



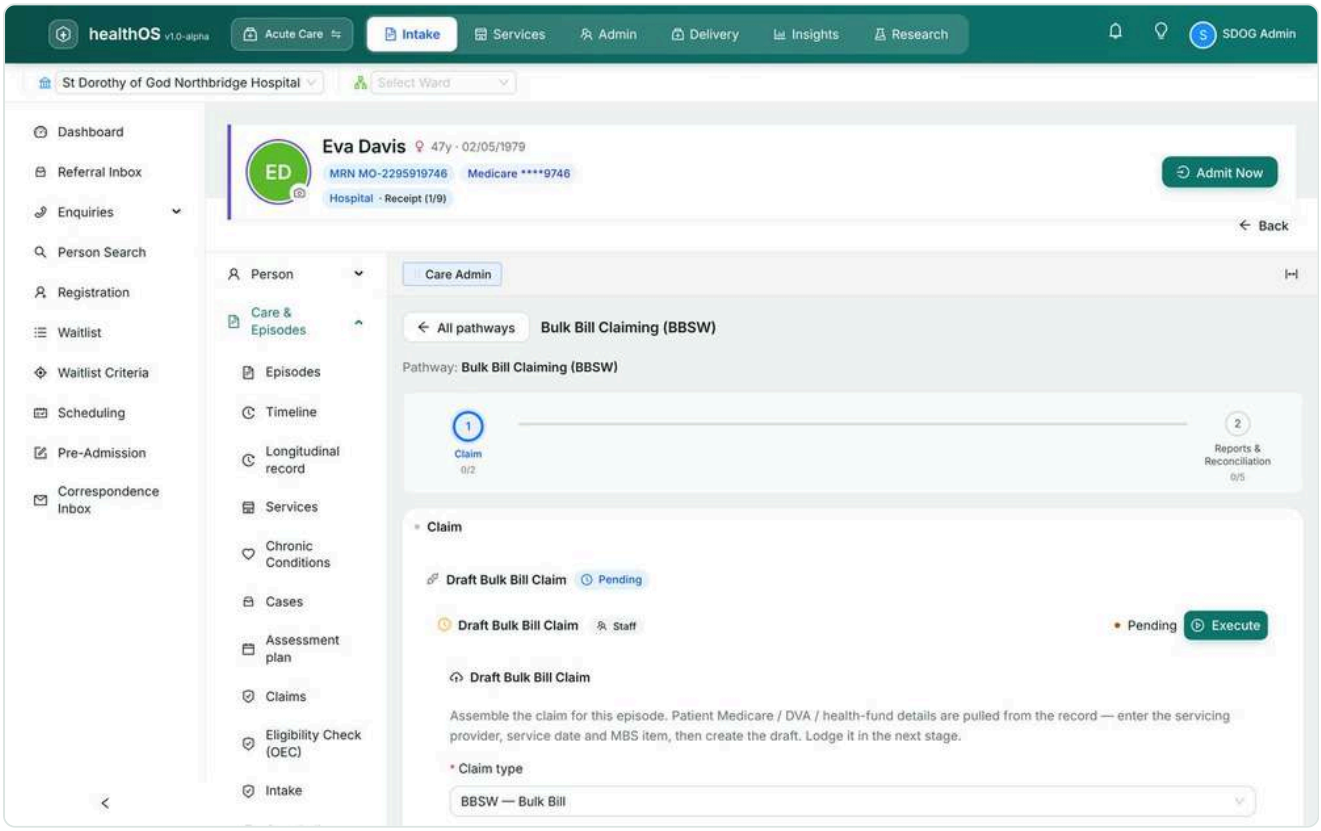
Patient Verification (OPV) filled in from the record: Medicare card number, IRN, name, sex and date of birth, ready for **Run PVM**.

3. **Read the answer.** Services Australia answered status 0, "Patient is eligible to claim for Medicare with details provided", and the card shows **Medicare card verified by Services Australia**. Every answer can be opened again later on **Online Claiming → Transactions → Detail** (section 14.6), which is how the answers below are shown.



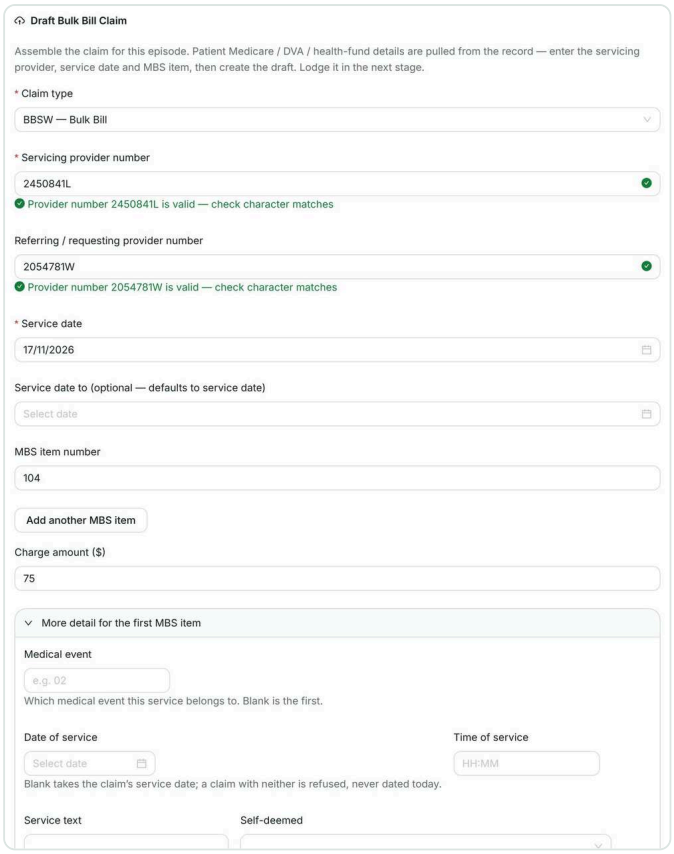
The verification as **Online Claiming → Transactions → Detail** shows it: service OPVW, response code 0 (the card verified), the Transaction ID and when it was sent.

4. **Open the claiming pathway.** On the chart, open **Care Admin → Bulk Bill Claiming (BBSW)** at its **Claim** stage.



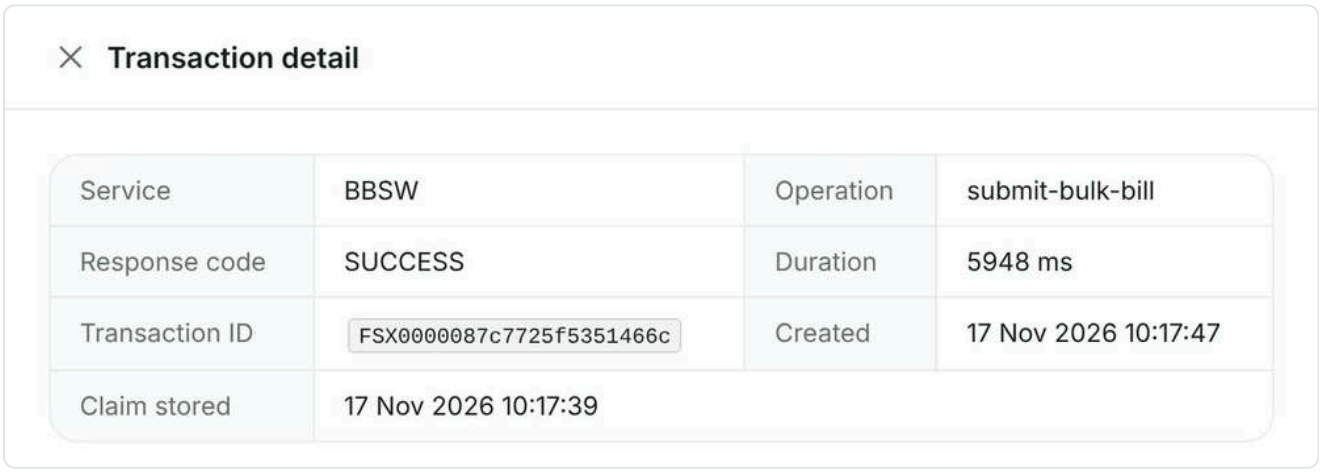
The **Bulk Bill Claiming (BBSW)** pathway open at its **Claim** stage.

5. **Draft the claim.** In **Draft Bulk Bill Claim**, the claim type is BBSW. Enter the servicing provider (2450841L here; the tick confirms it is valid), the referring provider (2054781W), the service date, MBS item 104 and its charge ($75.00), and the referral, then choose **Create draft claim** (section 7.1).



Draft Bulk Bill Claim filled in: claim type, servicing and referring providers (both confirmed valid), service date, item 104 and its charge.

6. **Lodge it.** In **Submit Bulk Bill Claim**, choose the draft, record the assignment of benefit (section 7.2) and choose **Lodge claim** (section 7.3).
7. **Read the answer.** Services Australia answered **SUCCESS**: they hold the claim and assess it overnight. Its processing and payment reports then arrive as section 14 describes.



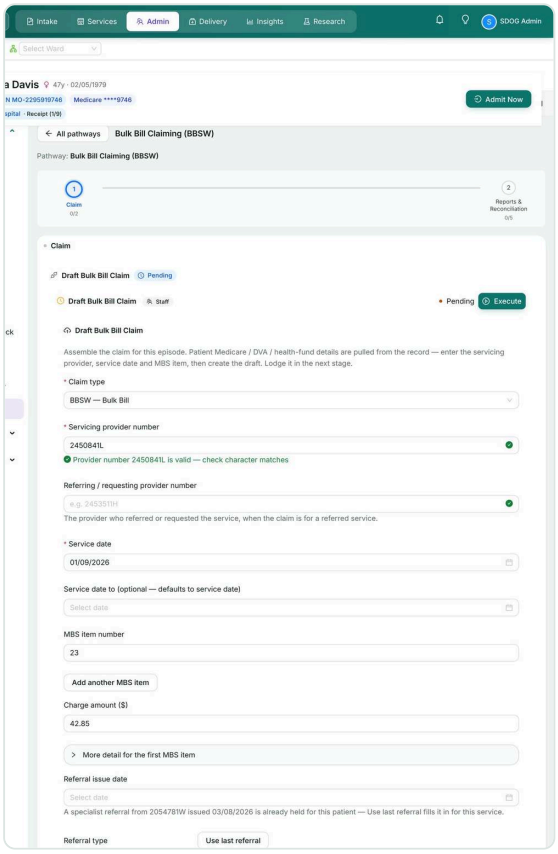
The bulk bill claim as **Online Claiming → Transactions → Detail** shows it: service BBSW, response code SUCCESS and the Transaction ID.

7.1 Draft the claim

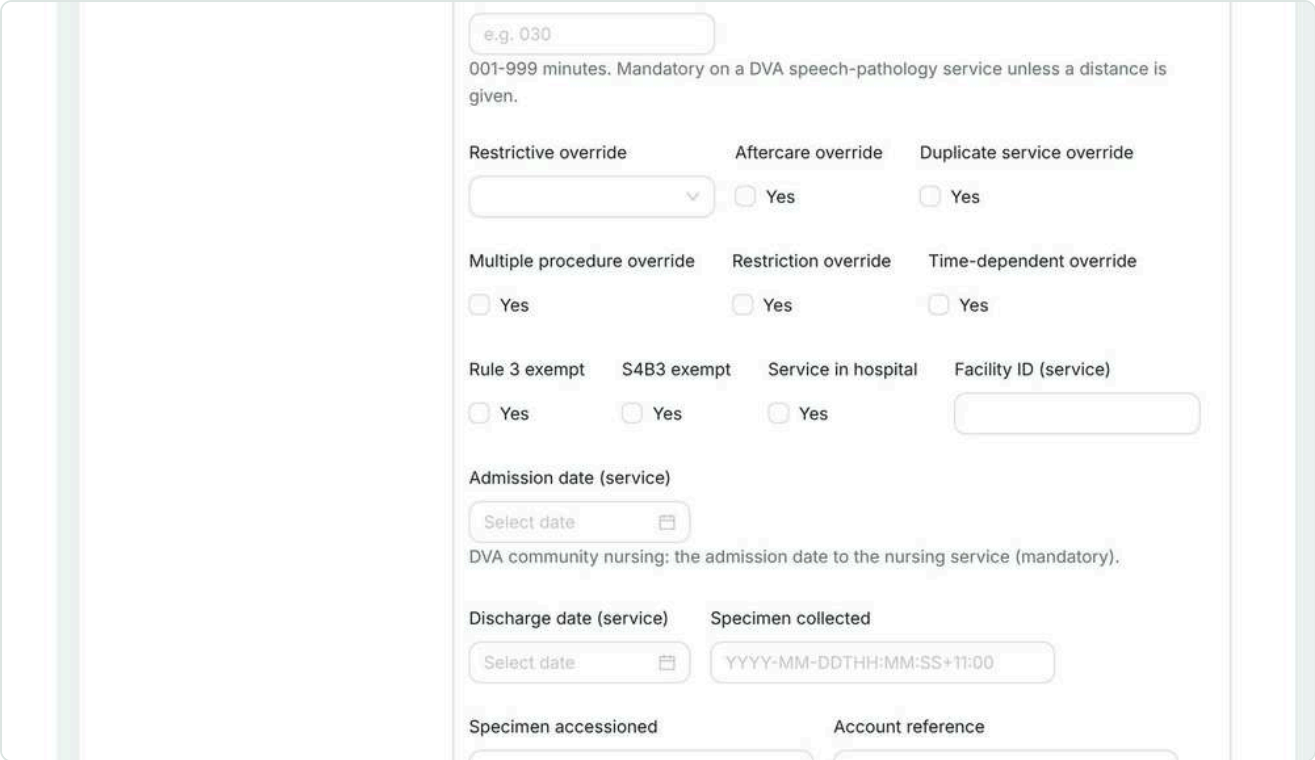
1. Open the **Claim** stage → **Draft Bulk Bill Claim**. **Claim type** is BBSW — Bulk Bill.

2. Enter the **Servicing provider number**. A tick and "Provider number … is valid — check character matches" confirms it is a real number.
3. Enter the **Service date**, the **MBS item number** and the **Charge amount ($)**. Use **Add another MBS item** for each further service.
4. For a referred service, enter the **Referring / requesting provider number**, **Referral issue date**, **Referral period (months)**, **Referral type** and **Referral period code**. If the patient's referral is already held, **Use last referral** fills these in.
5. Only if the claim needs them: **More detail for the first MBS item** holds item-level details (overrides, pathology dates, self-deemed code, time and duration); **Add medical event** starts a second visit in the same claim; and **Service type**, **Account paid**, **Service given in hospital**, **Facility ID** and **Payee provider number** cover pathology, in-hospital services and paying another provider.
6. Choose **Create draft claim**. The draft is saved and can be lodged now or later.

HealthOS checks the items as you type. For example, a specialist consultation and a pathology service (outside Group P9) cannot go in one claim, and the card says so before anything is sent. Lodge them as separate claims.



> Draft Bulk Bill Claim on the System: Bulk Bill Claiming (BBSW) pathway: claim type, servicing provider number (validated), service date, MBS item and charge.



> Item rules applied before lodgement: "These items cannot be claimed together — a specialist consultation and a pathology service (outside Group P9) cannot be claimed together. Send them as separate claims."

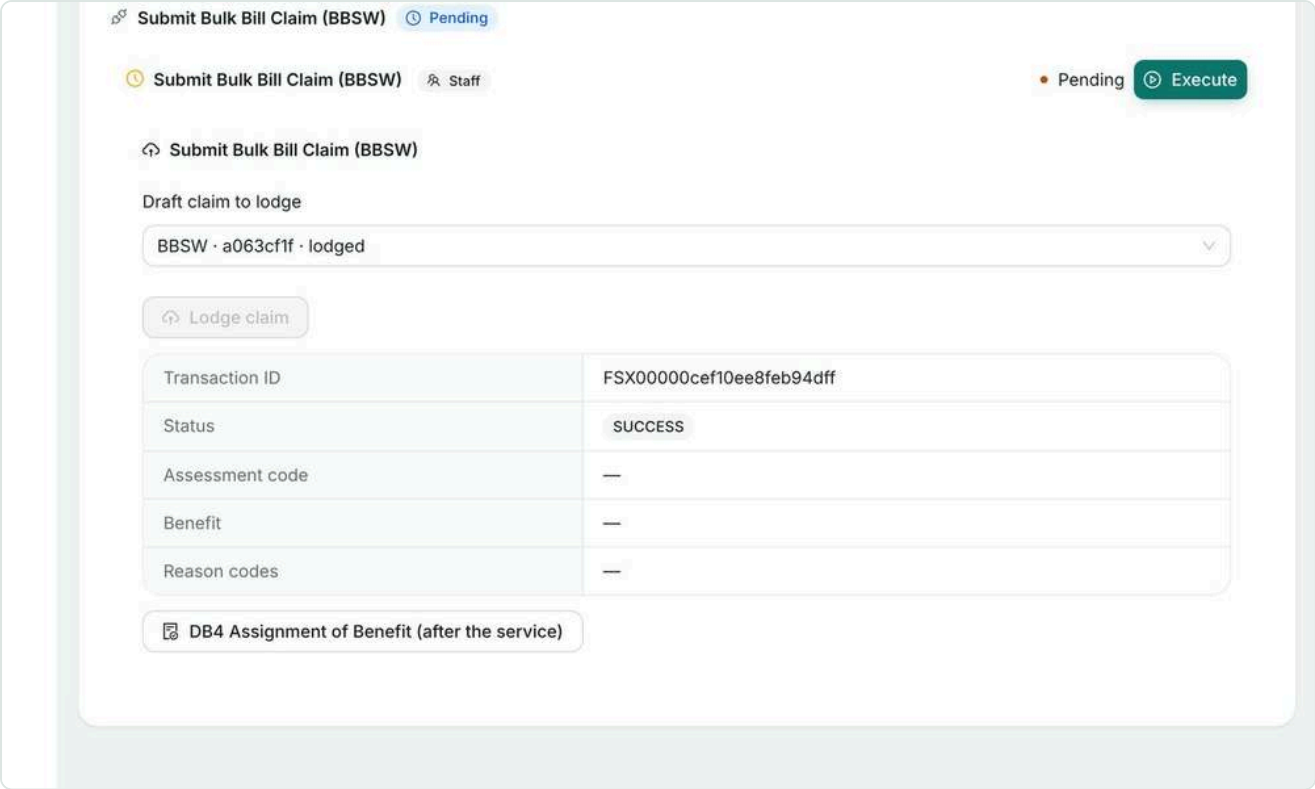
7.2 Record the patient's assignment of benefit (DB4)

A bulk bill claim cannot be lodged until the assignment is recorded.

1. In **Submit Bulk Bill Claim (BBSW)**, select the draft under **Draft claim to lodge**.
2. Under **Assignment of benefit (DB4)**, choose **Print the DB4 for signing** and have the patient sign it (section 13.3).
3. Choose how the patient assigned: **Signed DB4 form** or **Electronic assignment**. Enter a reference if you keep one.
4. Choose **Record assignment**. "Assignment recorded" appears.

7.3 Lodge the claim

1. Choose **Lodge claim**, then **Lodge** to confirm.
2. The card shows the **Transaction ID** and **Status**.
3. Choose **DB4 Assignment of Benefit (after the service)** to print the post-service copy of the form if your practice uses it.



Submit Bulk Bill Claim (BBSW) after lodgement: Transaction ID and status, and the DB4 Assignment of Benefit (after the service) button.

What to do next:

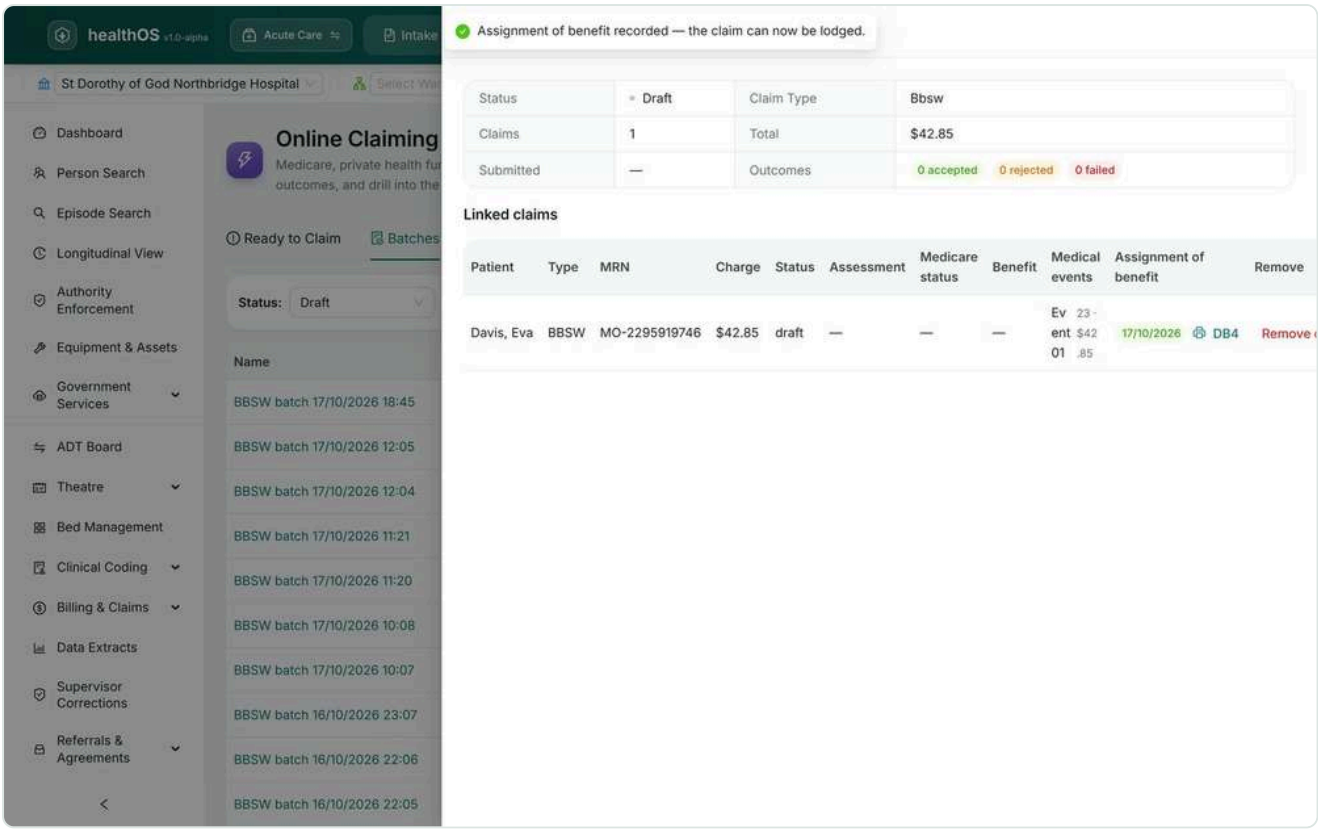
- **Received:** nothing more today. The next morning, HealthOS collects Medicare's processing report and shows the outcome on the claim and on **Online Claiming → Reports** (section 14). The payment report follows when Medicare pays.
- **Refused** (a red box with a code): nothing was claimed. Correct what the reason names and lodge again (section 15).

7.4 Lodge several claims together (batches)

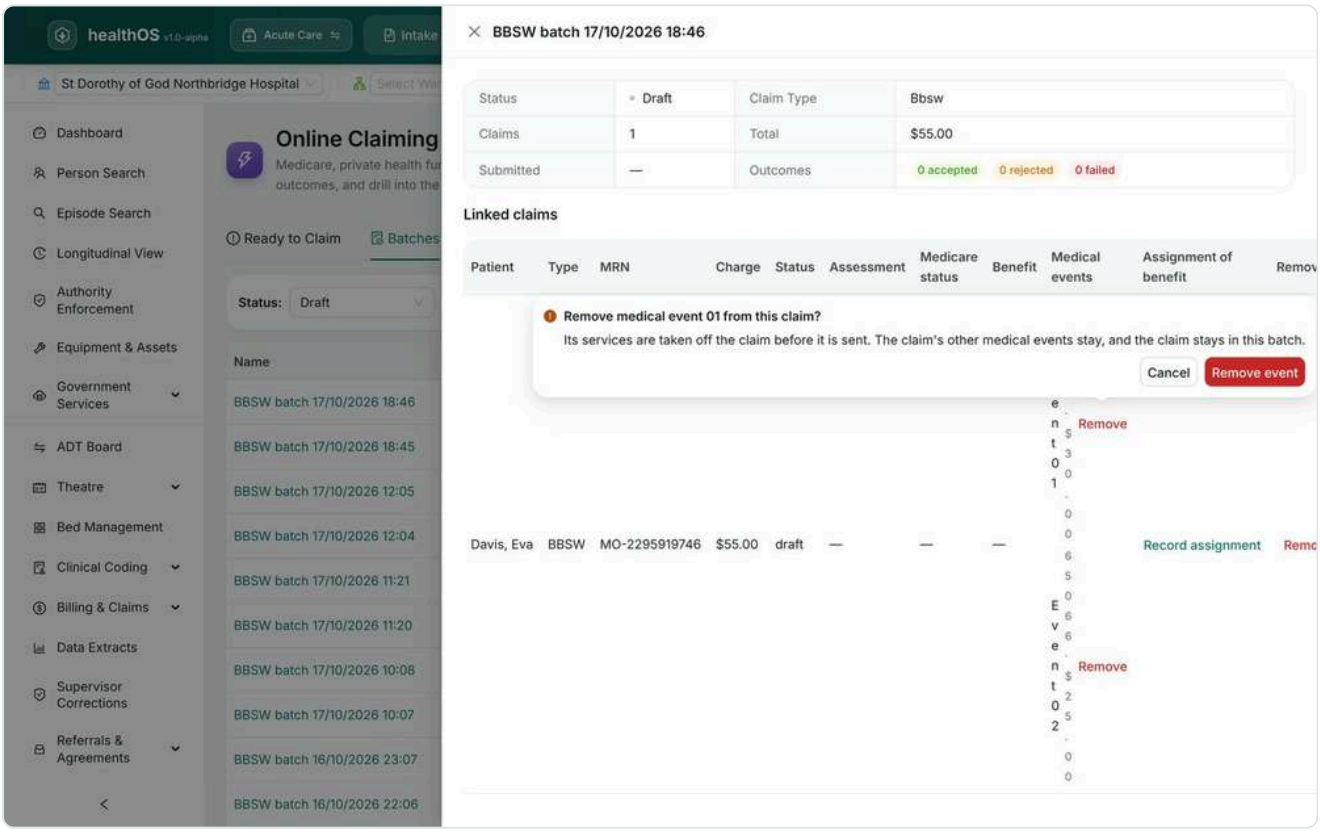
You can lodge bulk bill and DVA claims one at a time (7.3) or gather the day's drafts into a batch.

1. Open **PAS → Billing & Claims → Online Claiming → Ready to Claim**.
2. Tick the episodes whose drafts should go together and choose **Create batch (n)**. Enter a **Batch name**, the **Claim type** and an optional description, and choose **Create batch**.
3. Open **Batches** and select the batch name. Each claim is listed with its charge, status and **Assignment of benefit**.
4. For any bulk bill claim still without an assignment, choose **Record assignment** (date, how the patient assigned — signed DB4 or electronic — and a reference). **DB4** reprints the form.
5. To take a claim out before sending, choose **Remove** on its row and confirm **Remove event**. It goes back to Ready to Claim and can join another batch; the rest of the batch is untouched.
6. Choose **Submit** on the batch and confirm. The result reads "Submitted: n accepted, n rejected, n failed". Fix any rejected or failed claims (section 15).

To break a batch up before it is sent, choose **Cancel**: every claim is released so it can be batched again.



Online Claiming → Batches: a BBSW batch opened, with its linked claim, the recorded assignment of benefit (date and DB4) and the Remove control.



Removing one medical event from a batch before transmission: "Remove this medical event from the batch? The event returns to the unbatched pool and can be added to another batch."

SECTION 8

Patient claims and same-day delete

Use a patient claim when the patient wants their Medicare rebate on the spot, whether they have paid the account in full, paid part of it, or not paid yet. You lodge it **while the patient is with you** and Medicare answers within seconds.

Where: patient chart → **Care Admin** → **System: Patient Claiming (PCIW)**.

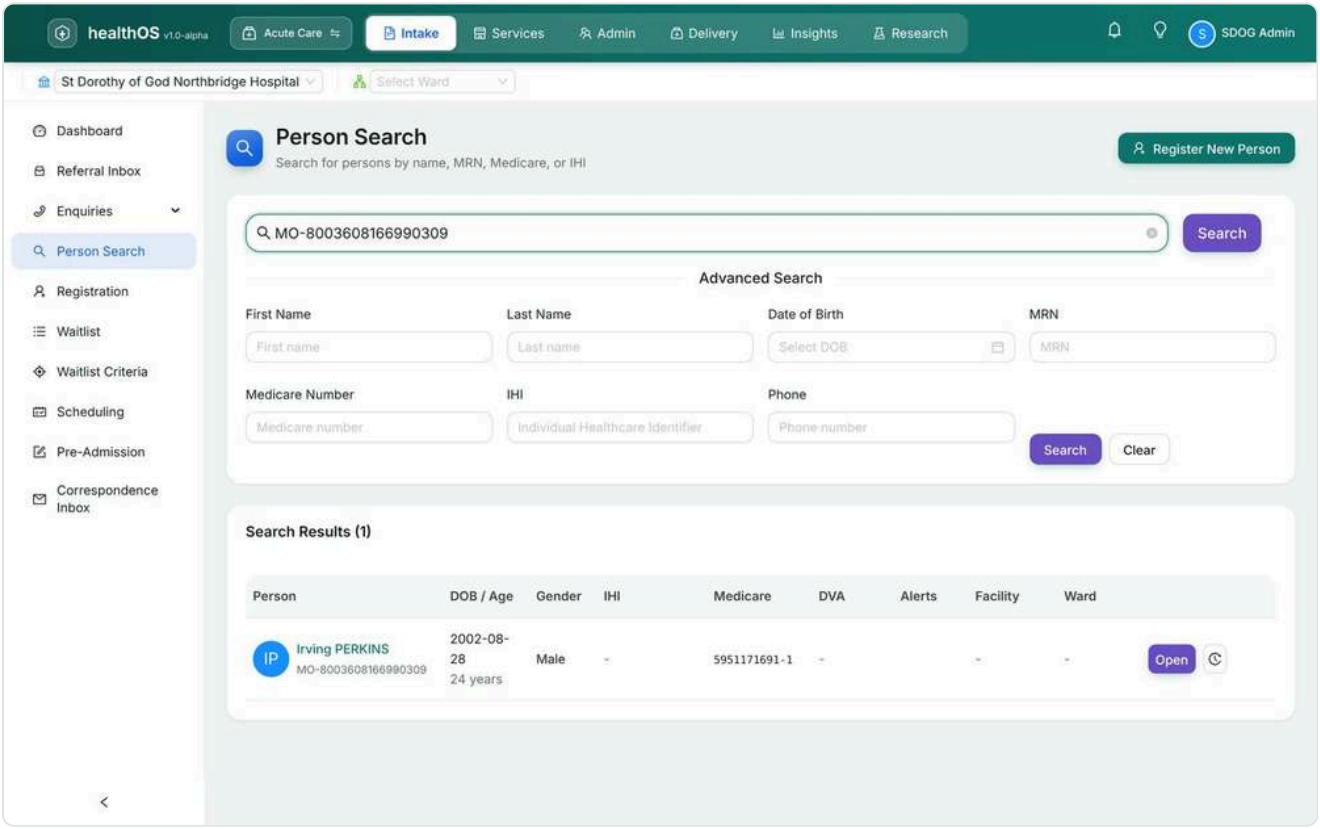
Before you start:

- The patient's Medicare card has been checked (section 5).
- You know whether the account is **paid in full**, **partially paid** or **not paid**.
- If someone else is claiming for the patient (for example a parent), you have that person's Medicare card and, for a payment to their bank, their account details.

Worked example: a patient claim from start to finish

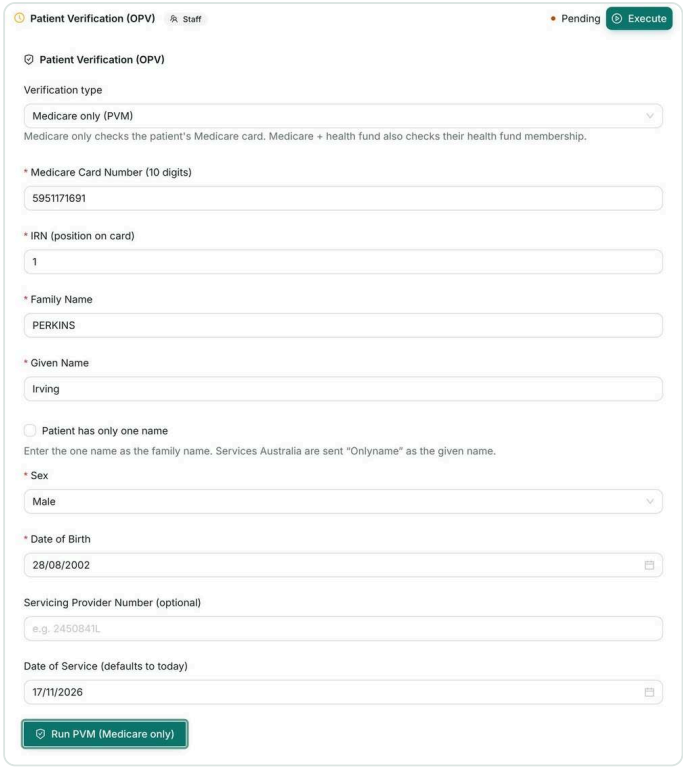
This example follows one patient, Irving Perkins, through a specialist patient claim, paid in full. It was lodged in Services Australia's test environment on 17 November 2026, with Services Australia's own test patients and providers. The numbered sections after it explain each step and its options.

1. **Find the patient.** Open **Person Search**, search by MRN, Medicare number or name, and open the patient's chart.



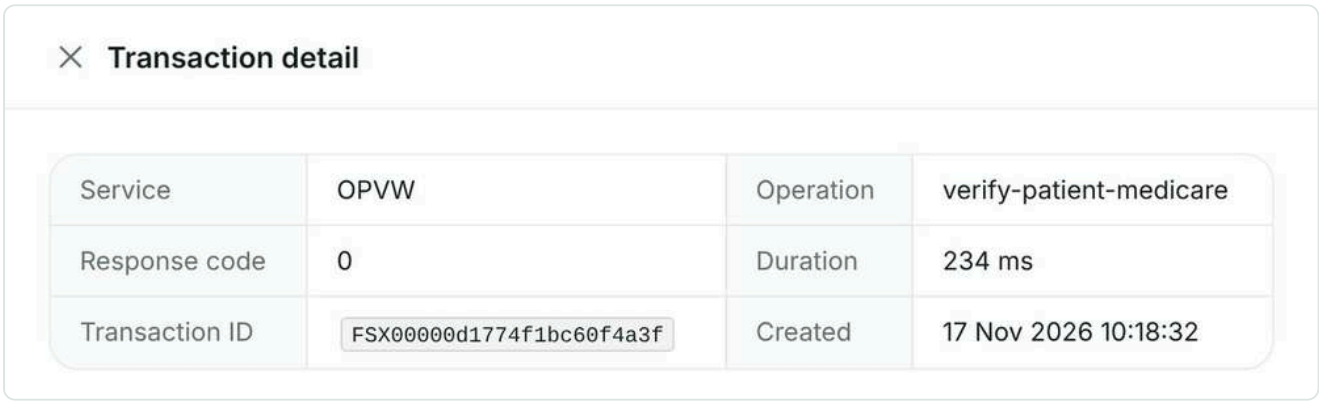
Person Search with the patient found by his MRN.

2. **Check the Medicare card** at the **Medicare Verification** stage of **Intake — Coverage & Eligibility**: choose **Medicare only (PVM)** and **Run PVM** (section 5.1).



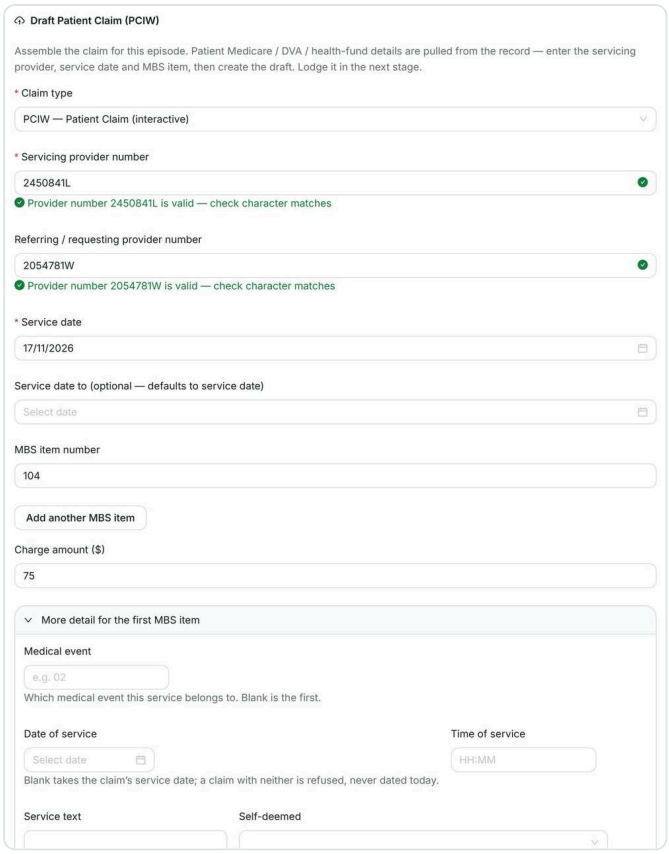
Patient Verification (OPV) filled in from the record, ready for **Run PVM**.

3. **Read the answer:** status 0, the card verified.



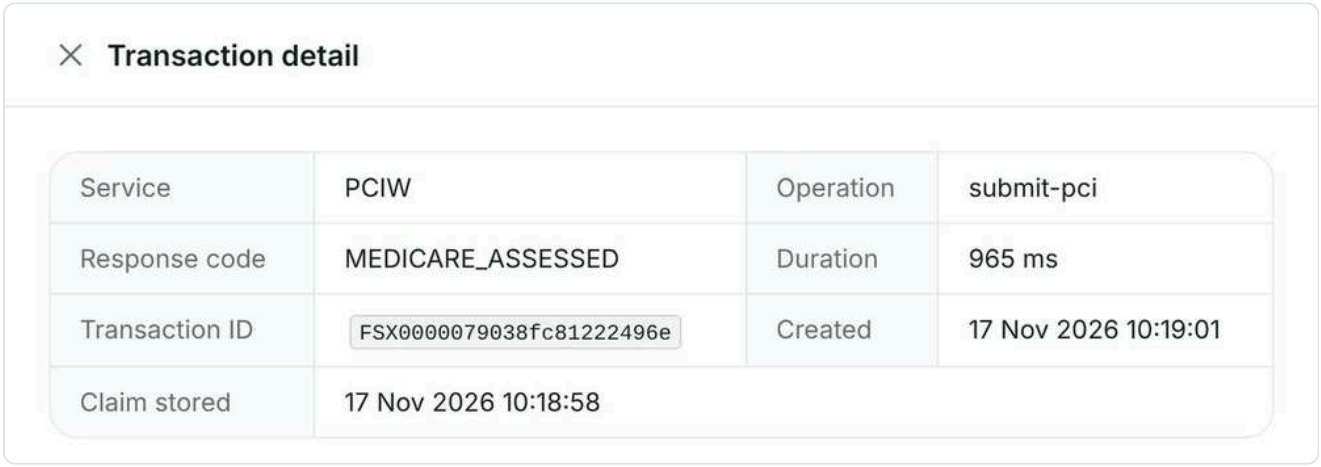
The verification on **Online Claiming → Transactions → Detail**: OPVW, response code 0 (the card verified) and the Transaction ID.

4. **Draft the claim.** On **Care Admin → Patient Claiming (PCIW)**, **Claim** stage, complete **Draft Patient Claim (PCIW)**: providers, service date, item 104, charge $75.00 and the referral, and set **Account paid** to **Paid in full**. Choose **Create draft claim**.



Draft Patient Claim (PCIW) filled in: claim type, servicing and referring providers, service date, item 104 and its charge.

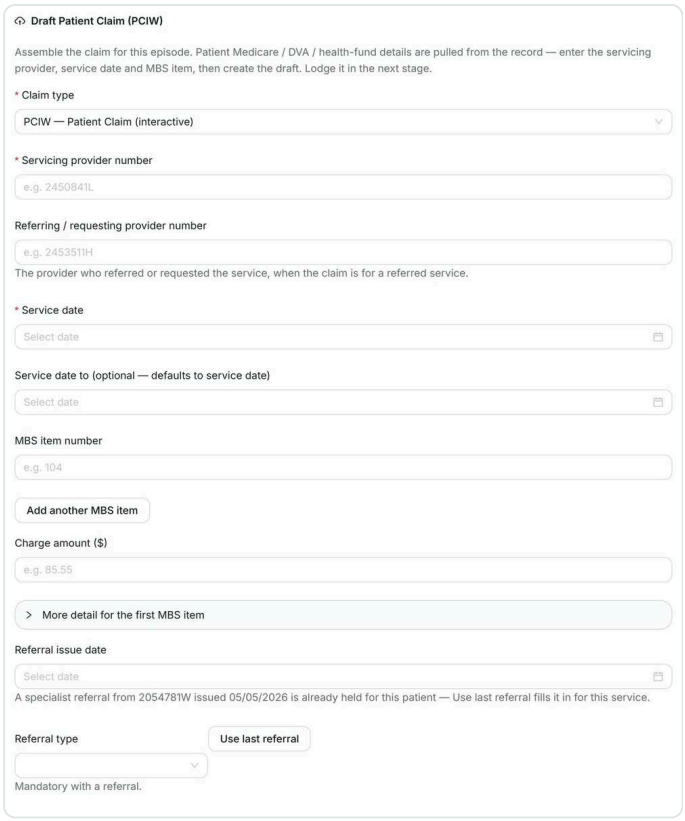
5. **Lodge it** in **Submit Patient Claim (PCIW)** (section 8.2). A patient claim is assessed while you wait.
6. **Read the answer.** Medicare answered **MEDICARE_ASSESSED** with a benefit of $75.00. Print the **Statement of Claim & Benefit Payment** for the patient (section 13.1).



The patient claim on **Online Claiming → Transactions → Detail**: service PCIW, response code MEDICARE_ASSESSED and the Transaction ID.

8.1 Draft the claim

1. On the **Claim** stage, open **Draft Patient Claim (PCIW)**.
2. Enter the servicing provider, service date, MBS items and charges, as for a bulk bill claim (section 7.1, steps 2 to 5).
3. Set **Account paid**: **Paid in full**, **Partially paid** or **Not paid**.
4. If someone other than the patient is the claimant, tick **Claimant is someone other than the patient** and enter their name, date of birth, Medicare card and IRN, address and phone. For a payment into their bank account, also enter the account name, BSB and account number.
5. Choose **Create draft claim**.



> The **Draft Patient Claim (PCIW)** card: claim type, servicing and referring providers, service date, MBS item and charge, and the referral. A referral already held for the patient is offered with **Use last referral**.

8.2 Lodge the claim

1. In **Submit Patient Claim (PCIW)**, select the draft and choose **Lodge claim**, then **Lodge**.
2. The answer appears in the card: the **Transaction ID**, the **Status**, and a line for each service with its item, assessment, benefit and any reason (code and Medicare's wording).

What to do next, by the status you see:

STATUS	DO THIS
MEDICARE_ASSESSED	Choose **Statement of Claim & Benefit Payment**, print it and give it to the patient (section 13.1). Tell the patient the benefit shown.
MEDICARE_PENDABLE	Medicare needs a person to look at it. Follow 8.4 now, while the patient is still with you.
Any other answer that accepts the claim (referred or stored)	Choose **Lodgement Advice**, print it and give it to the patient (section 13.2).
A red box, Lodgement failed	Nothing was claimed. Read the reason, correct the draft and lodge again (sections 15 and 17).

HealthOS offers either the Statement of Claim and Benefit or the Lodgement Advice for a claim, never both, because they describe different outcomes.

8.3 Lodge a stored claim later

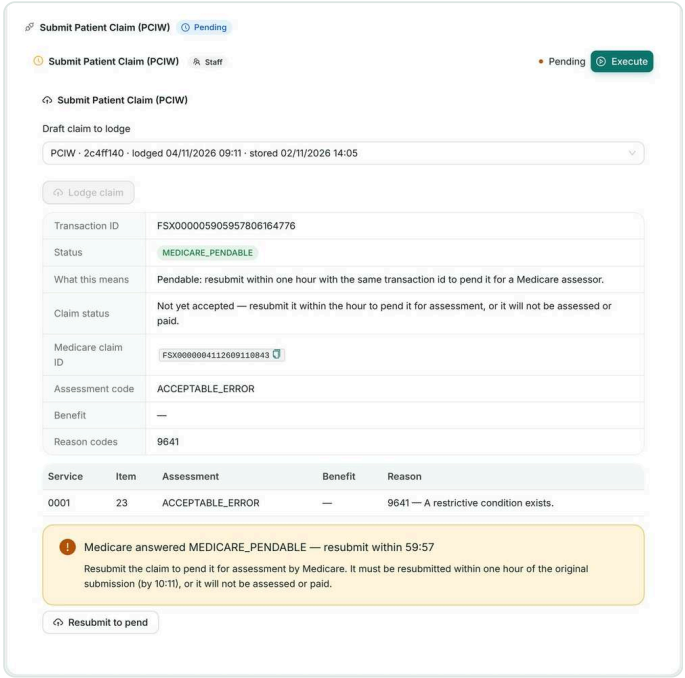
The draft is stored as soon as you choose **Create draft claim**. To lodge it later (for example when the patient has left, or a connection problem stopped you), open **Submit Patient Claim (PCIW)** on the same pathway, select the stored draft and choose **Lodge claim**.

8.4 A claim Medicare cannot assess straight away (pendable)

If Medicare answers **MEDICARE_PENDABLE**, for example with reason 9601 ("The claim needs to be referred to a Medicare Customer Services Officer for further assessment"), the card says **"Medicare answered MEDICARE_PENDABLE — Resubmit the claim to pend it for assessment by Medicare."**

1. Print the **Lodgement Advice** and give it to the patient.
2. Choose **Resubmit to pend** and confirm **Resubmit**. Do this promptly: the card shows how long is left.
3. The result appears under **Resubmitted**, with the status **MEDICARE_PENDED**. A Medicare officer will assess the claim later, and the outcome arrives in the reports.

The same action is on **Online Claiming → Transactions** as **Accept for assessment**. Do not use **Retry** for a pendable claim; HealthOS does not offer it.



A stored patient claim lodged on a later day and answered MEDICARE_PENDABLE: the service line with reason 9641 ("A restrictive condition exists"), the hour left to resubmit, and Resubmit to pend.

8.5 A follow-up visit under the same referral

On the draft, choose **Use last referral** to fill in the referral details from the first visit.

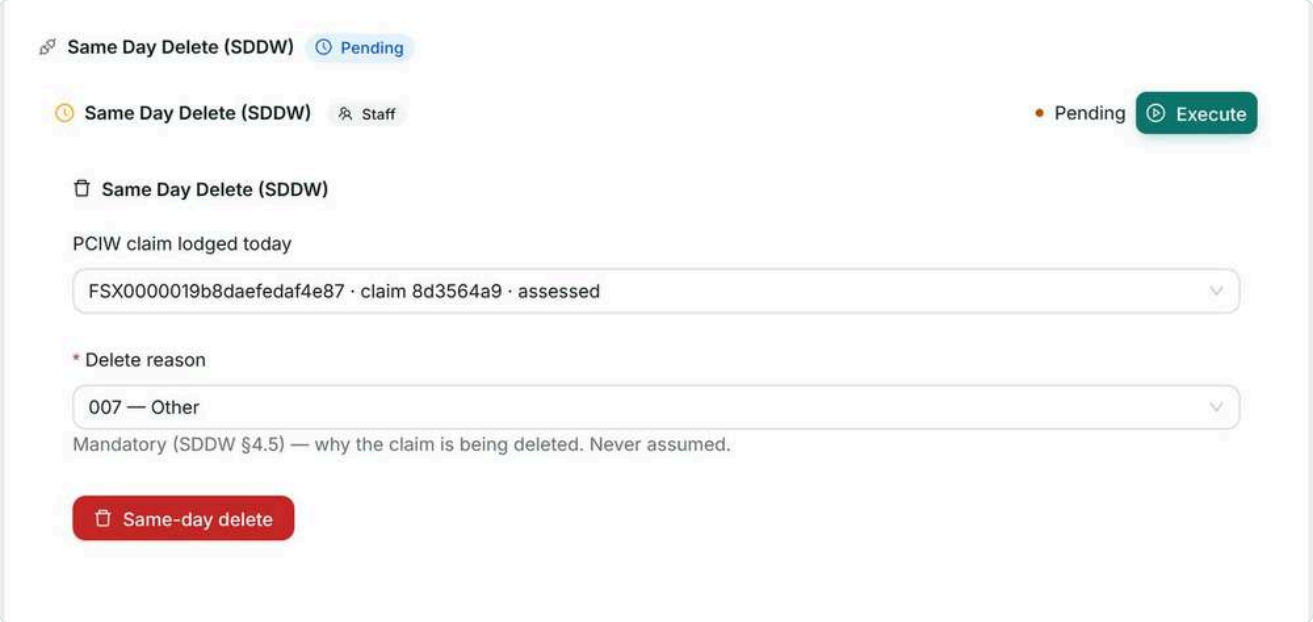
8.6 Withdraw a patient claim on the day (same-day delete)

If a patient claim was lodged by mistake (wrong patient, wrong item), you can withdraw it at Services Australia, but **only on the day it was lodged**, and only once Medicare has **assessed** it.

1. On **System: Patient Claiming (PCIW)**, open the **Reports & Reconciliation** stage → **Same Day Delete (SDDW)**.
2. Choose the claim under **PCIW claim lodged today**. Only claims that can be deleted are listed.

3. Optionally choose a **Delete reason code** (001–005, for example 001 Incorrect Patient Selection).
4. Choose **Same-day delete** and confirm **Delete**. **This cannot be undone.**

A pended claim is listed after the assessed ones, but Services Australia refuse to delete it (code 9645), and the card warns you before you send. A claim from an earlier day cannot be deleted: email HealthOS support with its Transaction ID and we arrange the correction with Medicare.



Same Day Delete (SDDW): the assessed PCIW claim lodged today selected, the optional delete reason code, and the Same-day delete button.

SECTION 9

DVA claims

Use a DVA claim for a veteran with a DVA card. There are two kinds: **DVAW** for medical services (general practice, specialist, pathology) and **VAAW** for allied health and community nursing. DVA assesses them overnight and pays you.

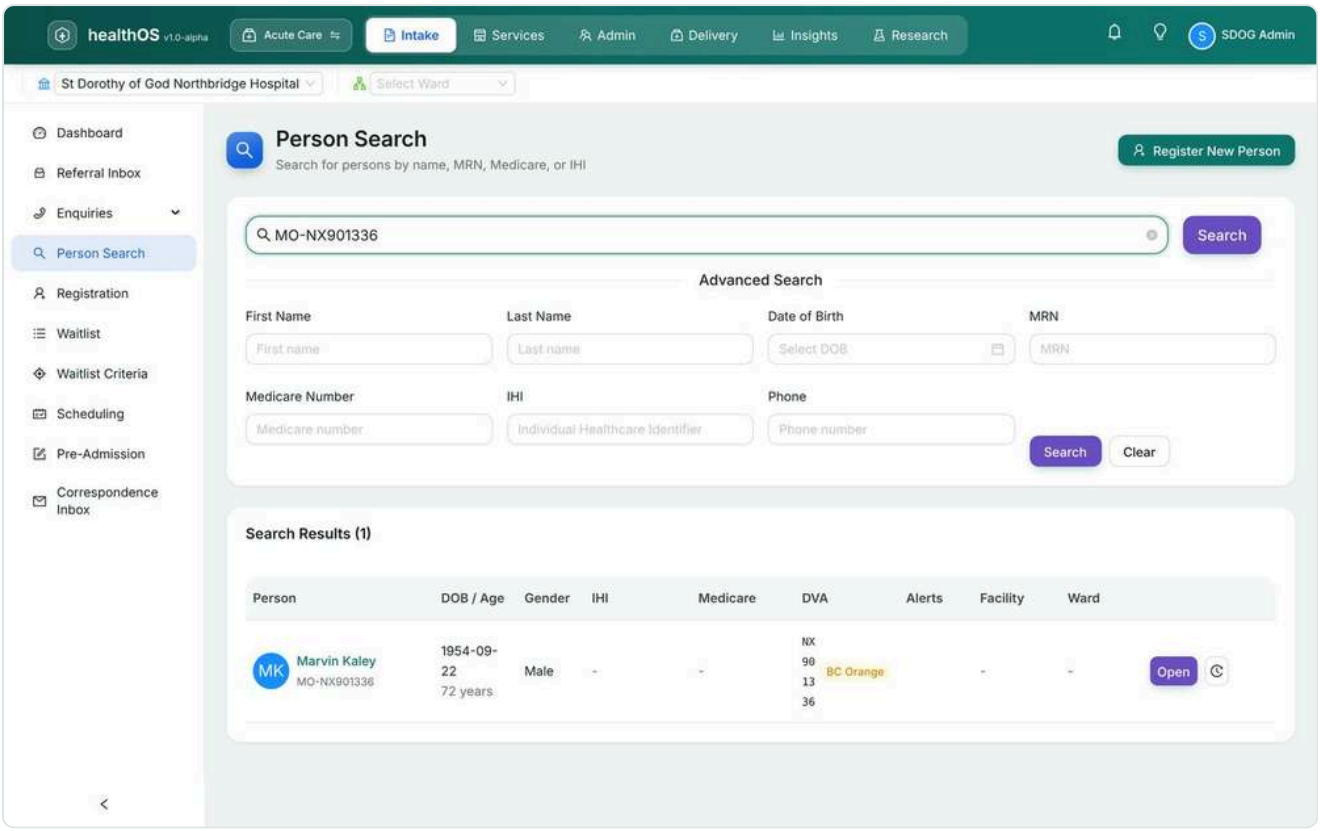
Where: patient chart → **Care Admin** → **System: DVA Claiming (DVAW / VAAW)**. (A single DVA claim can also be lodged from **PAS → Billing & Claims → DVA**.)

Before you start: check the veteran's DVA card (section 5.3). Their DVA file number then comes from their record.

Worked example: DVA medical and allied health claims

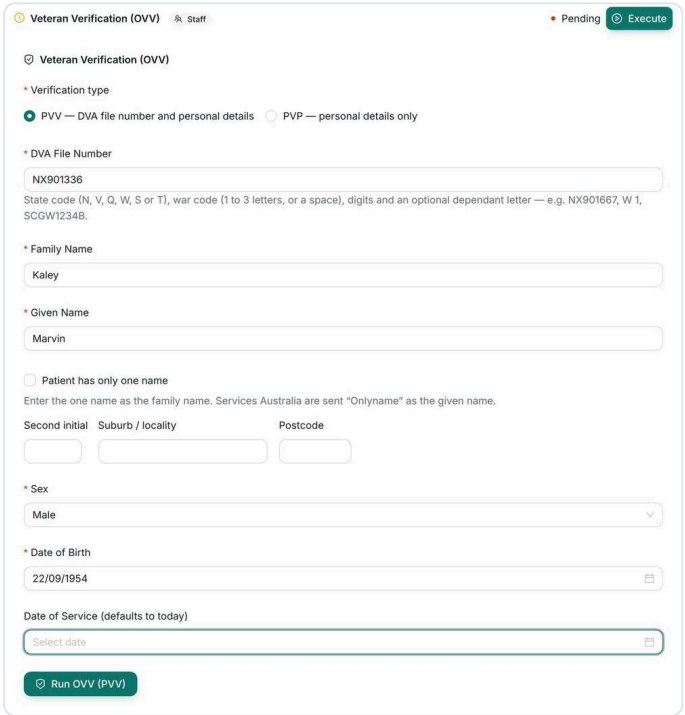
This example follows two veterans, Marvin Kaley and Kerrie Jason, through a DVA medical claim and a DVA allied health claim. It was lodged in Services Australia's test environment on 17 November 2026, with Services Australia's own test patients and providers. The numbered sections after it explain each step and its options.

1. **Find the veteran.** Open **Person Search** and search by MRN, DVA file number, Medicare number or name, and open the chart.



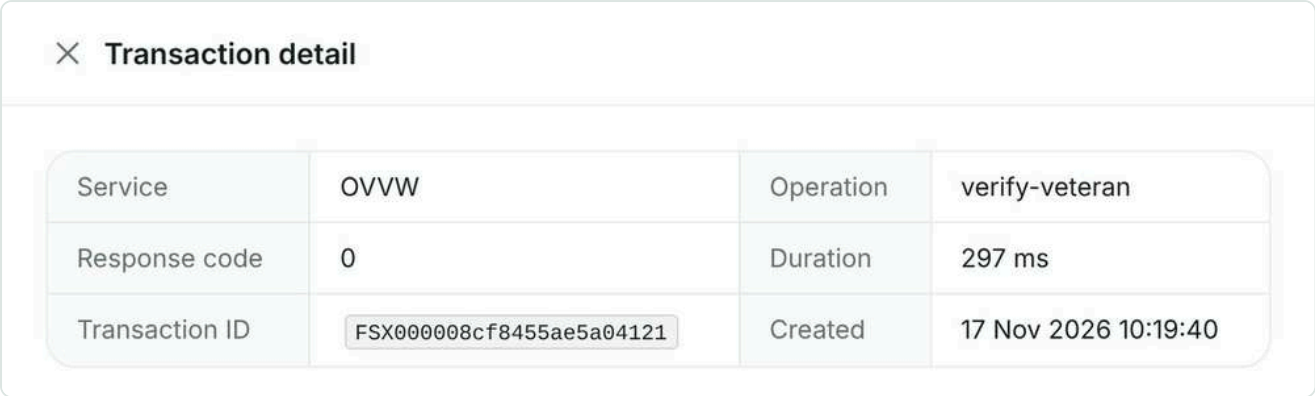
Person Search with the veteran found.

2. **Check the DVA card** at the **Veteran Verification (OVV)** stage of **Intake — Coverage & Eligibility**, and choose **Run OVV** (section 5.3).



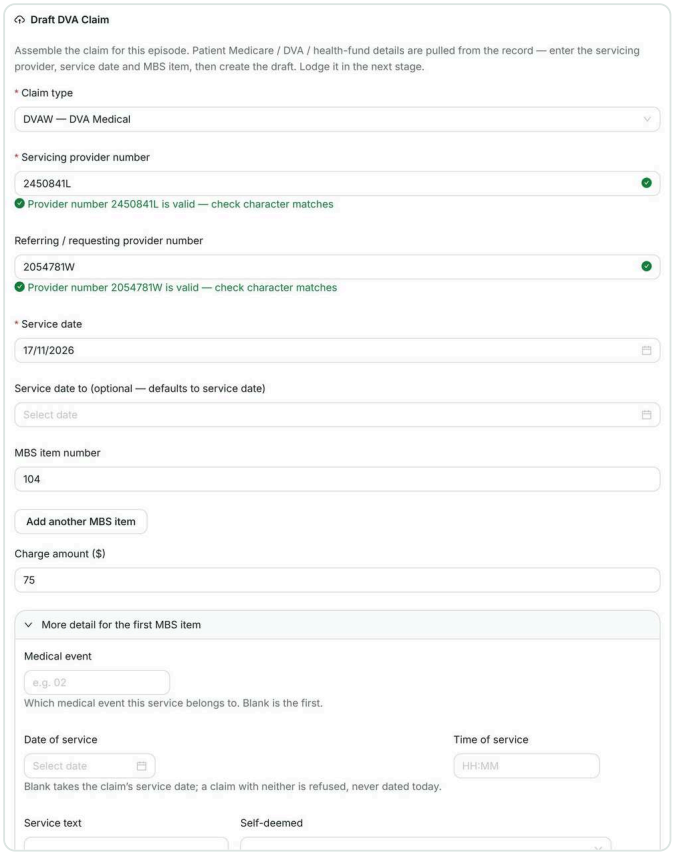
Veteran Verification (OVV) filled in from the record: the DVA file number and the veteran's details, ready for **Run OVV**.

3. **Read the answer:** the veteran and their entitlement verified by DVA, status 0.



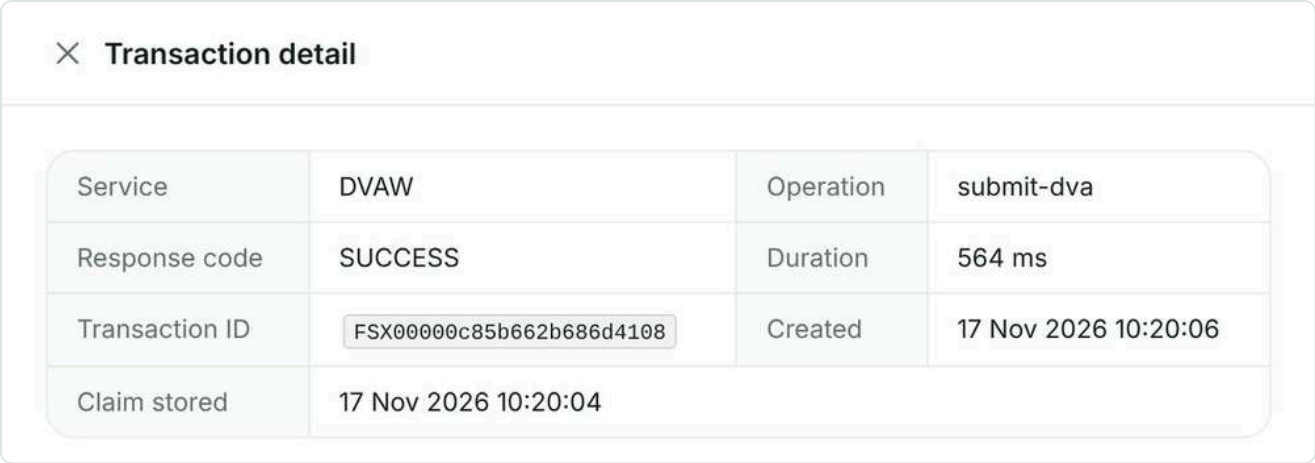
The veteran verification on **Online Claiming → Transactions → Detail**: OVVW, response code 0 (the veteran verified) and the Transaction ID.

4. **Draft the medical claim.** On **Care Admin → DVA Claiming (DVAW / VAAW)**, **Claim** stage, complete **Draft DVA Claim** with claim type **DVAW — DVA Medical**: providers, service date, item 104, its charge and the referral. Choose **Create draft claim**.



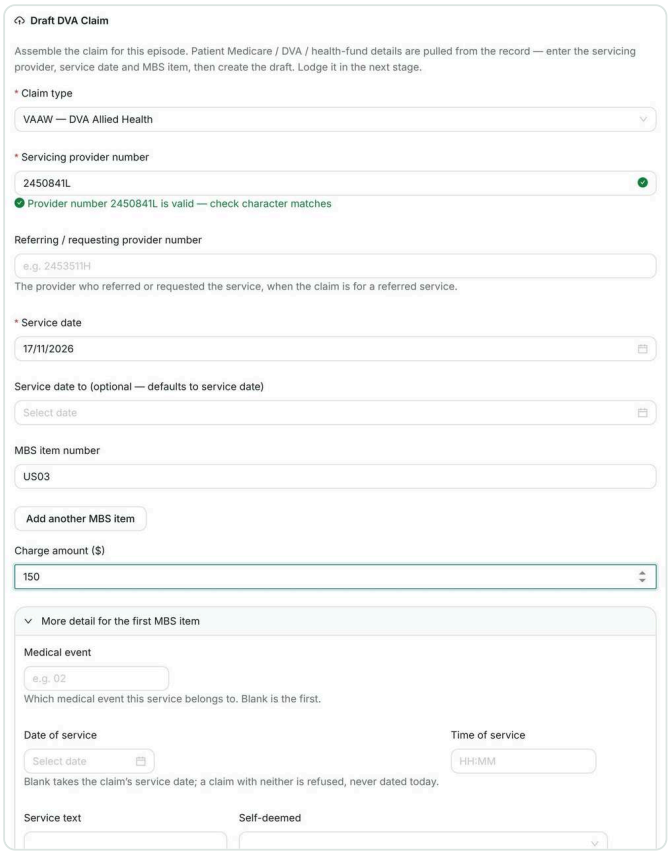
Draft DVA Claim for a medical claim (DVAW): providers, service date, item 104 and its charge.

5. **Lodge it** in **Submit DVA Claim** after the veteran signs the voucher (section 13.5). DVA answered **SUCCESS**.

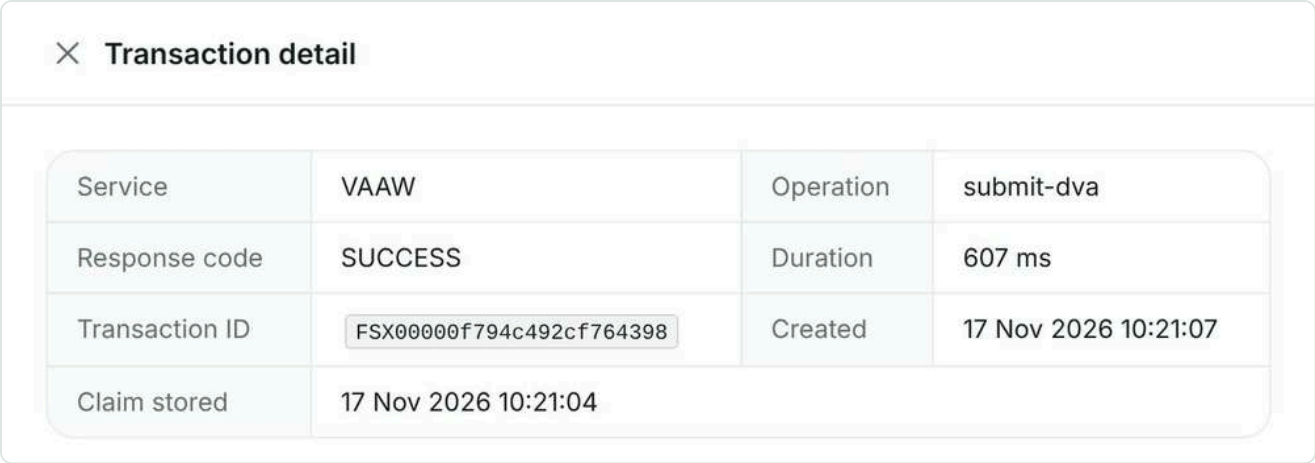


The DVA medical claim on **Online Claiming → Transactions → Detail**: service DVAW, response code SUCCESS and the Transaction ID.

6. **An allied health claim** is the same, with claim type **VAAW — DVA Allied Health** and the allied health item: here psychology item US03 at $150.00 for Kerrie Jason, after her own veteran check. DVA answered **SUCCESS**. The processing and payment reports follow overnight (section 14).



Draft DVA Claim for an allied health claim (VAAW): psychology item US03 and its charge.



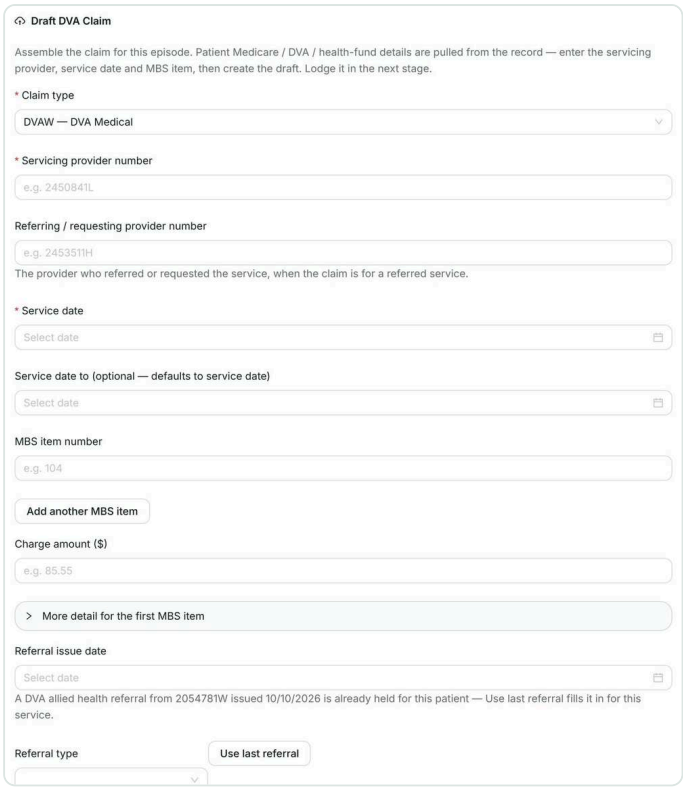
The allied health claim on **Online Claiming → Transactions → Detail**: service VAAW, response code SUCCESS and the Transaction ID.

9.1 Draft and lodge a DVA claim

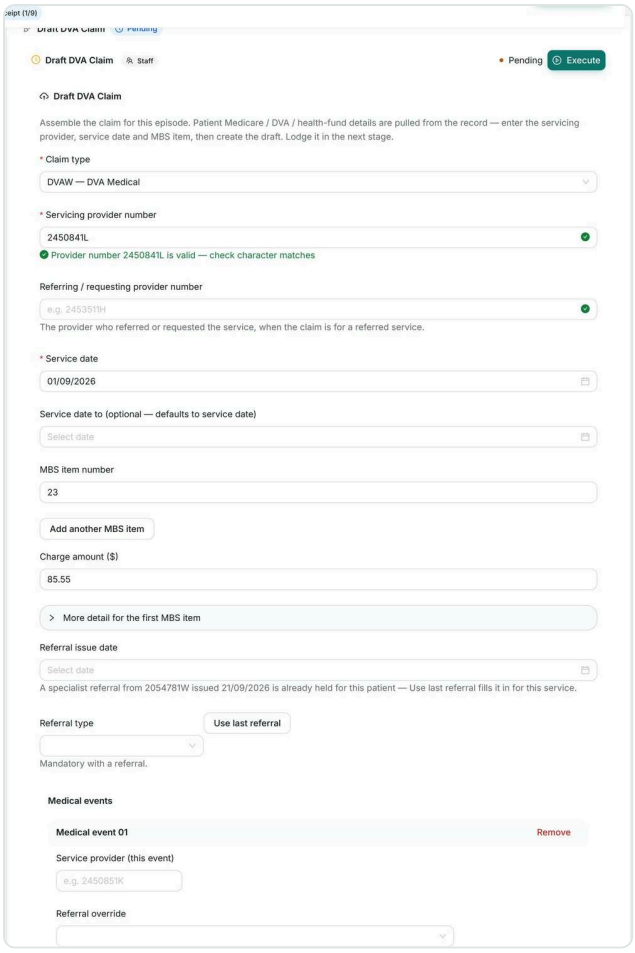
1. On the **Claim** stage, open **Draft DVA Claim**.
2. Choose the **Claim type**: **DVAW** for medical, or **VAAW** for allied health and community nursing.
3. Enter the provider, service date, items and charges as for a bulk bill claim (section 7.1, steps 2 to 5), and choose **Create draft claim**.
4. In **Submit DVA Claim**, select the draft. Under **DVA claim voucher**, choose **Print the voucher for signing** and have the veteran sign it (section 13.5).
5. Choose **Lodge claim** and confirm. The Transaction ID and status are shown.

What to do next: nothing more today if the claim was received. The next morning HealthOS collects DVA's processing report and the outcome shows on the claim and on **Online Claiming → Reports**. If it was refused, correct it and lodge again (section 15).

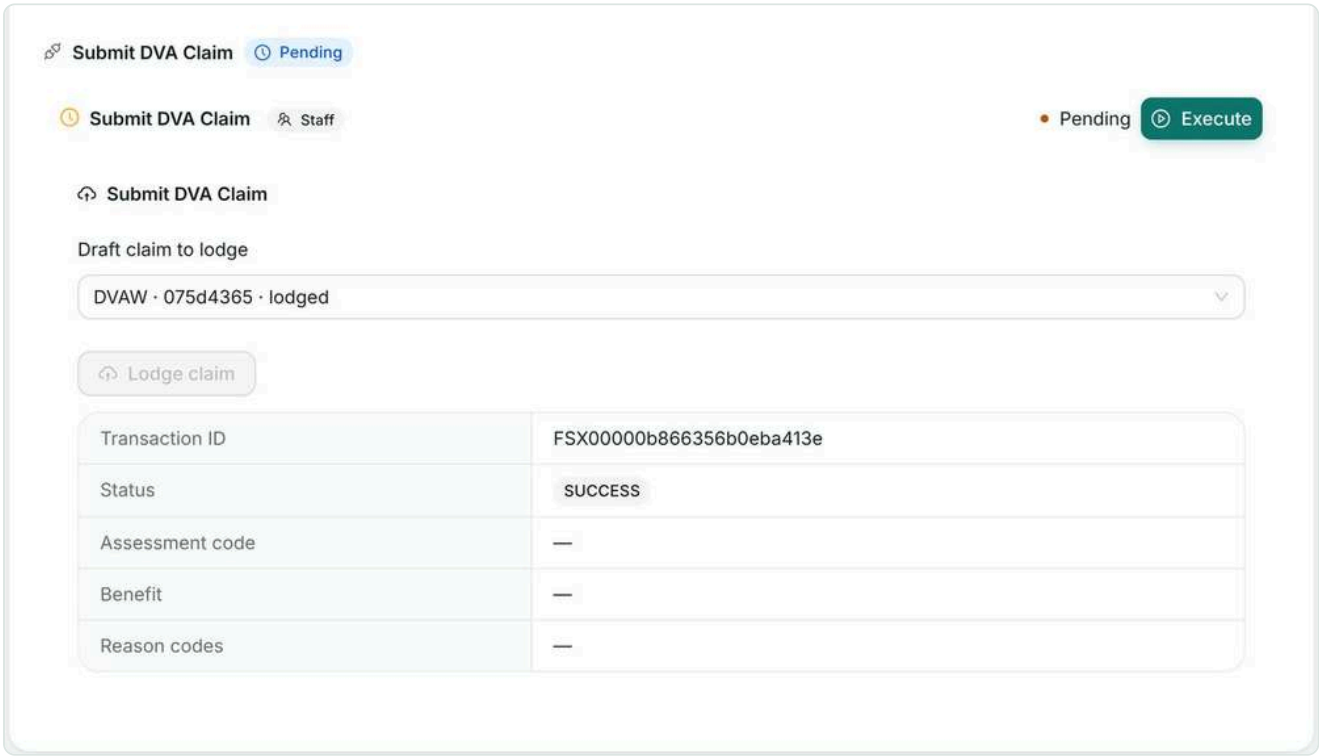
DVA claims can be batched like bulk bill claims (section 7.4).



> The **Draft DVA Claim** card on the DVA Claiming pathway: claim type (DVAW for medical, VAAW for allied health), providers, service date and MBS item. An allied health referral already held for the veteran is offered with **Use last referral**.



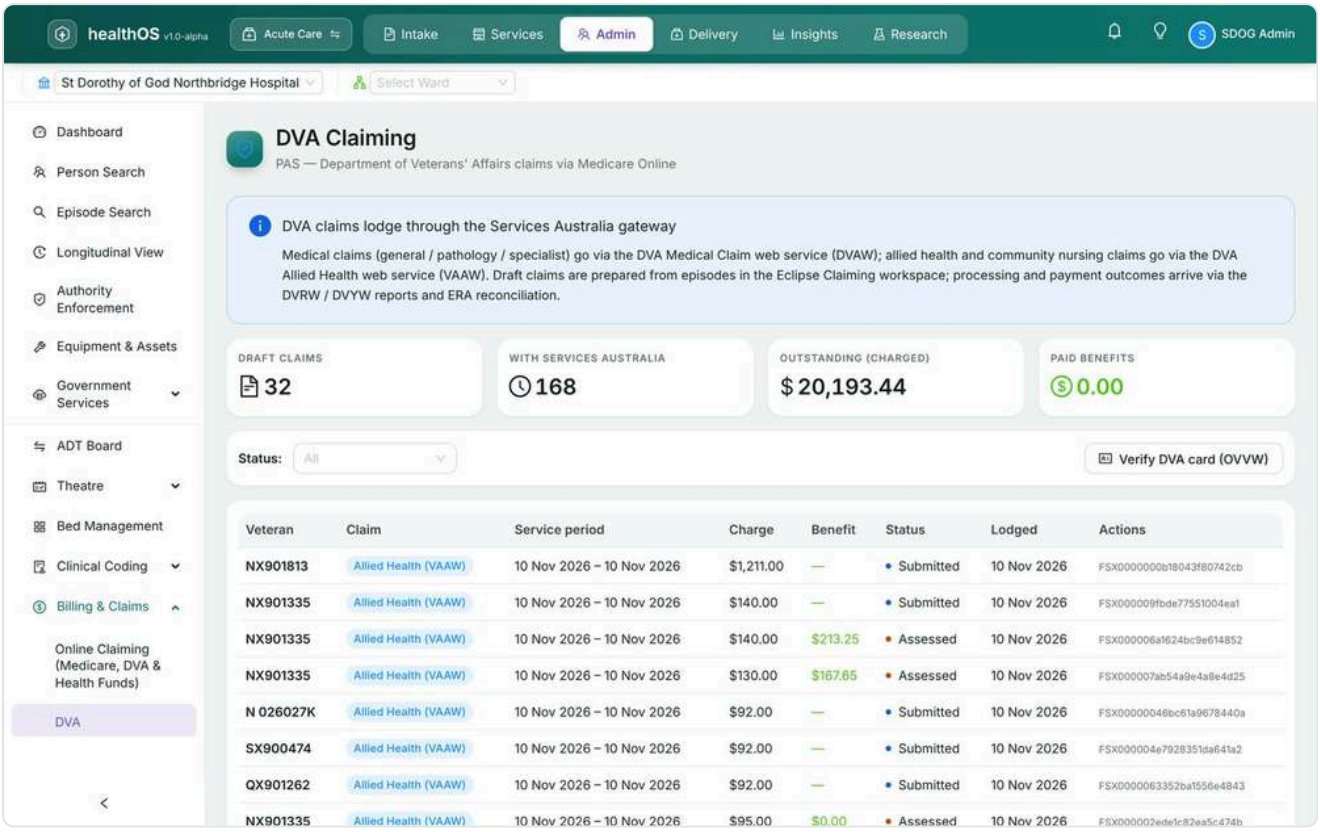
Draft DVA Claim on the System: DVA Claiming (DVAW / VAAW) pathway.



Submit DVA Claim after lodgement: the Transaction ID and status.

9.2 All DVA claims

PAS → Billing & Claims → DVA lists every DVA claim with its veteran, claim type, service period, charge, benefit, status and Transaction ID.



PAS → Billing & Claims → DVA: every DVA claim with its veteran, claim type, service period, charge, benefit, status and Transaction ID.

SECTION 10

In-patient medical claims (IMC)

An in-patient medical claim sends the **doctors' medical services** for a private in-patient to the health fund and Medicare together, through ECLIPSE. (The hospital's own charges go on an in-hospital claim, section 11.)

The claim is sent through one of four channels: Medicare Benefit (mb), Medicare Only (mo), Agreement (ag) or Patient Claim (pc).

Where: patient chart → **Care Admin** → **System: Private Hospital Claiming (IMCW / IHCW)**.

Before you start:

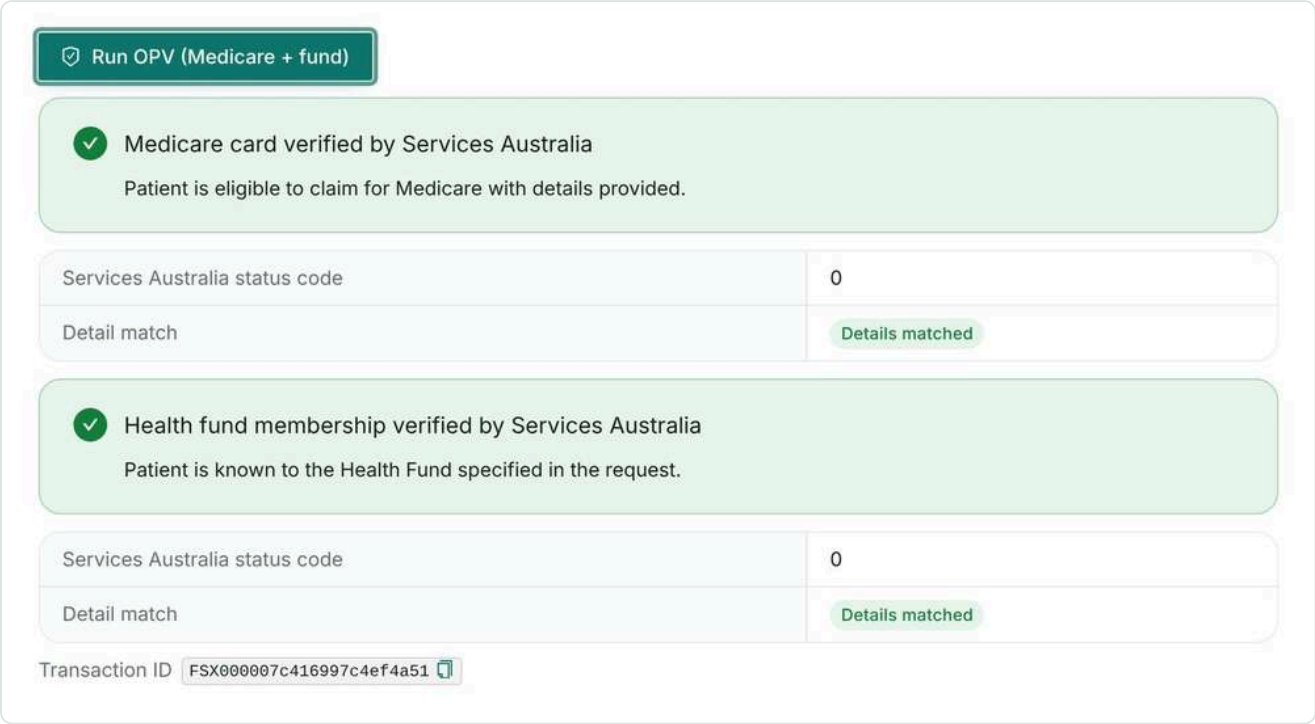
- The patient's Medicare card and health fund membership have been checked (section 5).
- If an eligibility check was done before admission (section 6), the draft can start from it.

Worked example: an in-patient medical claim from start to finish

This example follows Curt Creighton, a privately insured patient, from his eligibility check to an in-patient medical claim under his fund's agreement. It was lodged in Services Australia's test environment on 17

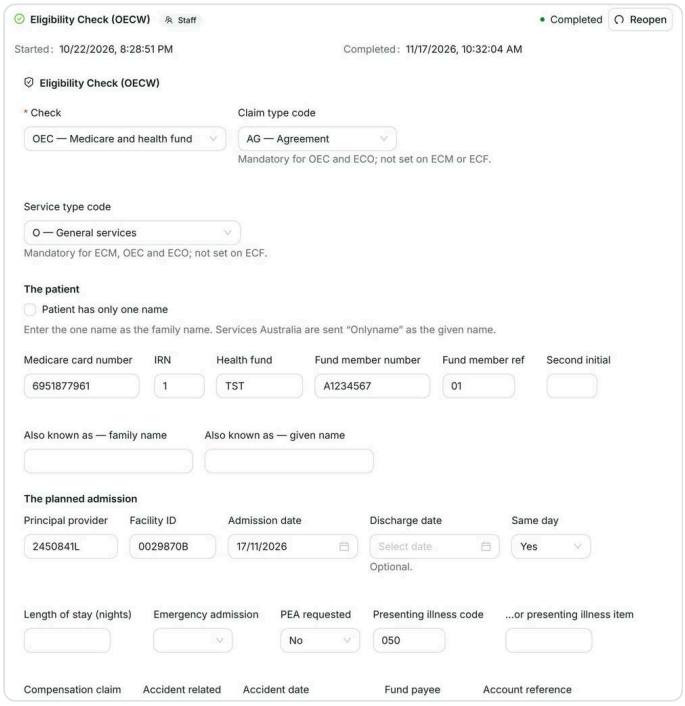
November 2026, with Services Australia's own test patients and providers. The numbered sections after it explain each step and its options.

1. **Check the Medicare card and fund.** At the **Medicare Verification** stage of **Intake — Coverage & Eligibility**, choose **Medicare + health fund (OPV)** and run it (section 5.2). Both came back verified.



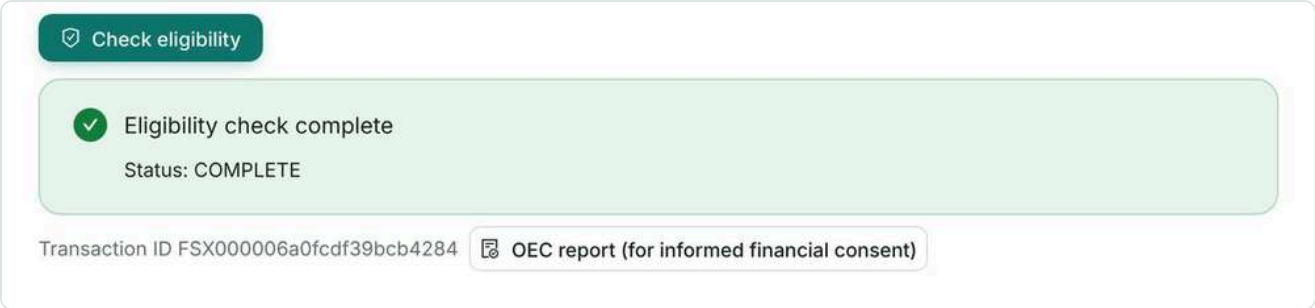
The answer on the **Patient Verification (OPV)** card: the Medicare card and the health fund membership both verified by Services Australia, with the status codes and the Transaction ID.

2. **Check eligibility before the admission** with the **Eligibility Check (OECW)** (section 6): choose the check (Medicare and health fund, **OEC**), and complete the fund, the planned admission and its MBS services. Tick that the patient authorised the check and choose **Check eligibility**.



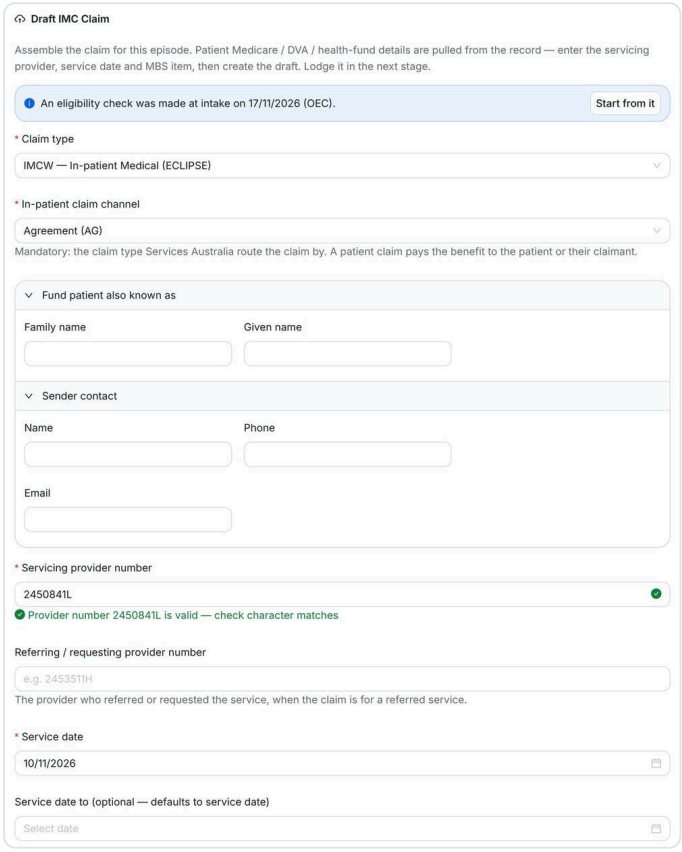
Eligibility Check (OECW) filled in: the check type (Medicare and health fund), the patient's Medicare and fund details, the planned admission and the MBS service.

3. **Read the answer.** The check came back **COMPLETE**: Medicare assessed item 30187 (schedule fee $307.60) at a benefit of $75.00 against the $75.00 charge. **OEC report** opens the printable report for the patient's informed financial consent (section 13.6).



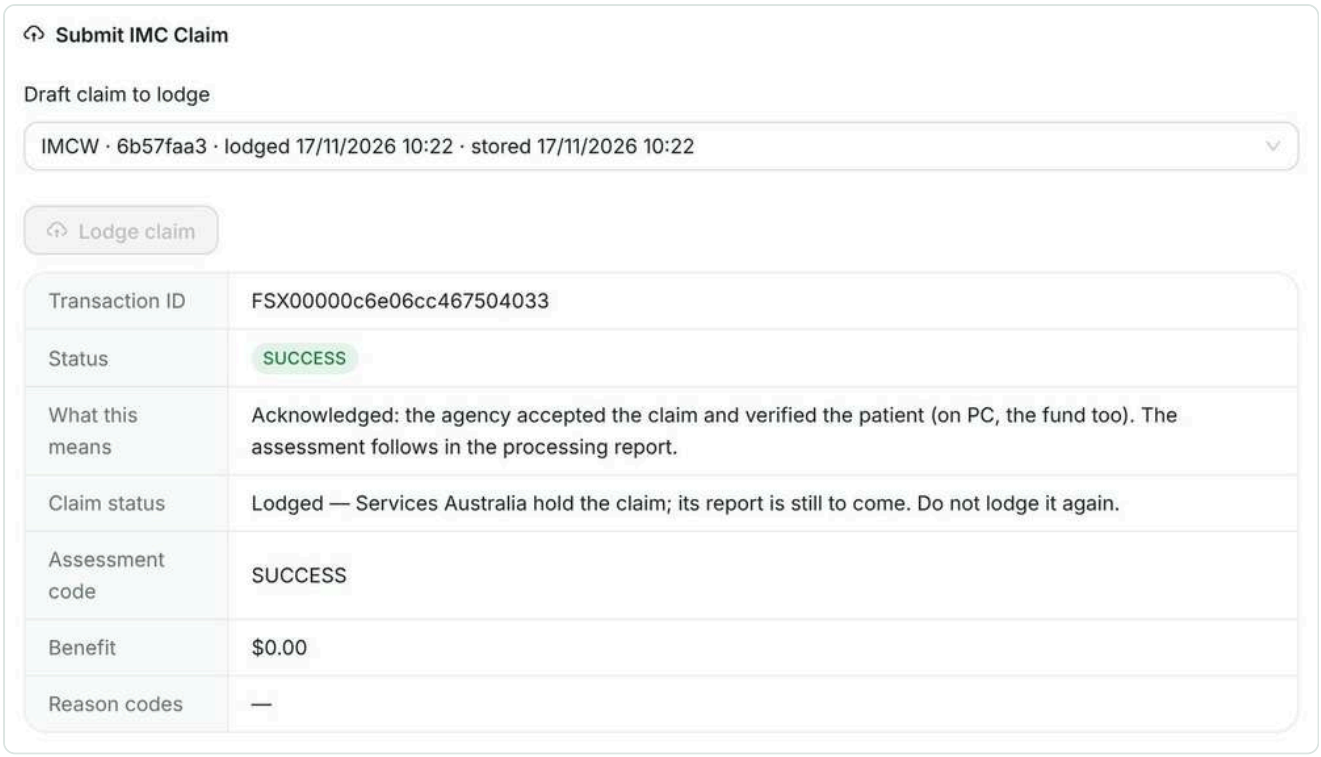
> The answer: **Eligibility check complete**, status COMPLETE, with the Transaction ID and the **OEC report** button.

4. **Draft the claim.** On **Care Admin → Private Hospital Claiming (IMCW / IHCW)**, **Claim** stage, complete **Draft IMC Claim**: claim type IMCW, channel **Agreement (AG)**, the providers, the service date and the MBS items. Choose **Create draft claim**.



> **Draft IMC Claim** filled in: the eligibility check made at intake offered with **Start from it**, the claim type, the channel, the providers and the service date.

5. **Lodge it** in **Submit IMC Claim**, with the patient's consent (section 13.4). Services Australia answered **SUCCESS**: they hold the claim, and the claim report and the fund's remittance advice follow (section 14).



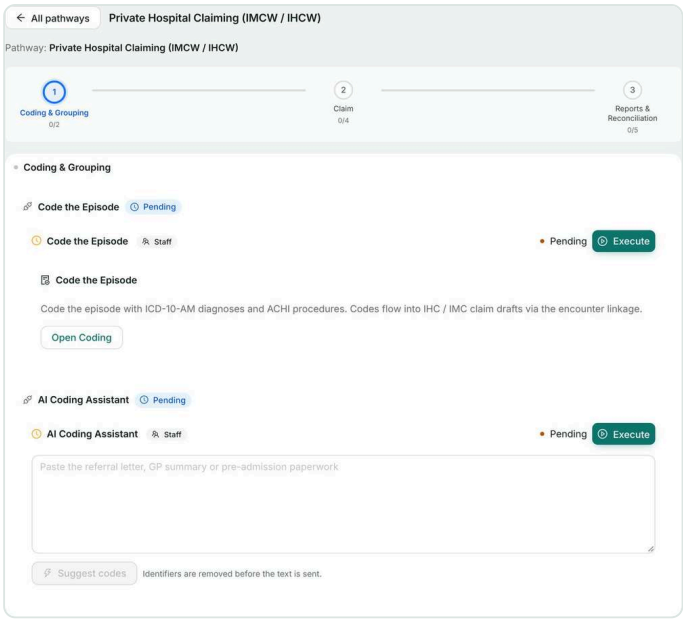
Submit IMC Claim after lodgement: the Transaction ID, the status SUCCESS and what it means: the claim is held, and its report is still to come.

10.1 Code, draft and lodge an in-patient medical claim

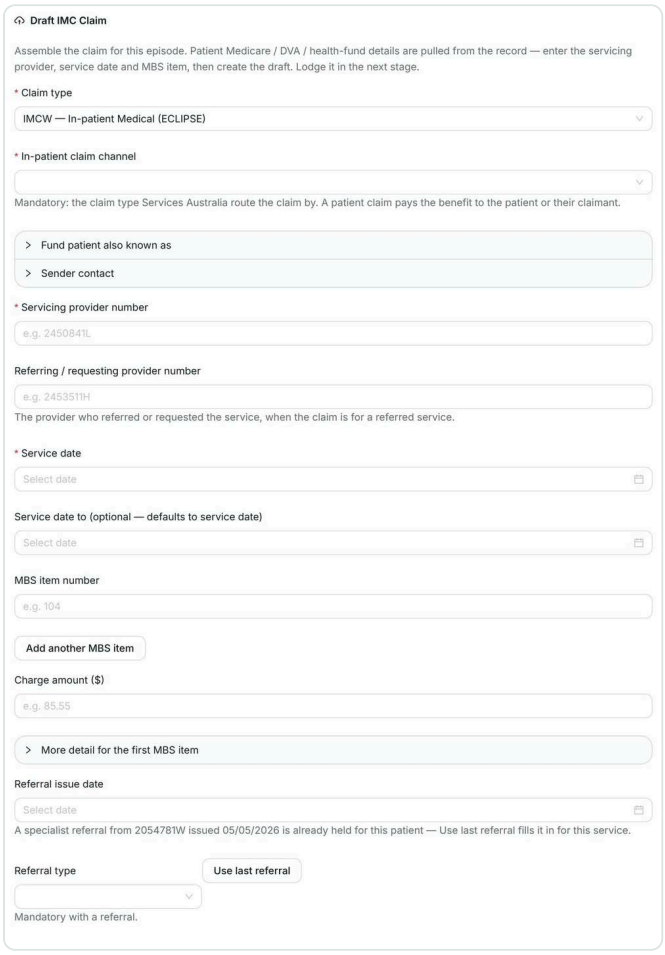
1. On the **Coding & Grouping** stage, open **Code the Episode** and assign the diagnoses (ICD-10-AM) and procedures (ACHI). **AI Coding Assistant** can suggest codes for a coder to review.
2. On the **Claim** stage, open **Draft IMC Claim** and choose IMCW. If an eligibility check was done, choose **Start from it**.
3. Complete the provider, service dates, items and charges; the health fund (**Health fund**, **Fund member number**, **Fund member ref**); and **Accident related**, **Benefit assignment**, **Account reference id**, **Facility ID**, **Compensation claim**, **Fund payee**, the admission and discharge dates and the payee provider.
4. Choose **Create draft claim**.
5. In **Submit IMC Claim**, select the draft.
6. **For a patient claim only:** choose **Show the consent and declaration**, have the patient read it (section 13.4), and tick **The patient has consented to this claim being lodged**. **Lodge claim** stays unavailable until you do.
7. Choose **Lodge claim** and confirm. The Transaction ID and status are shown.

What to do next:

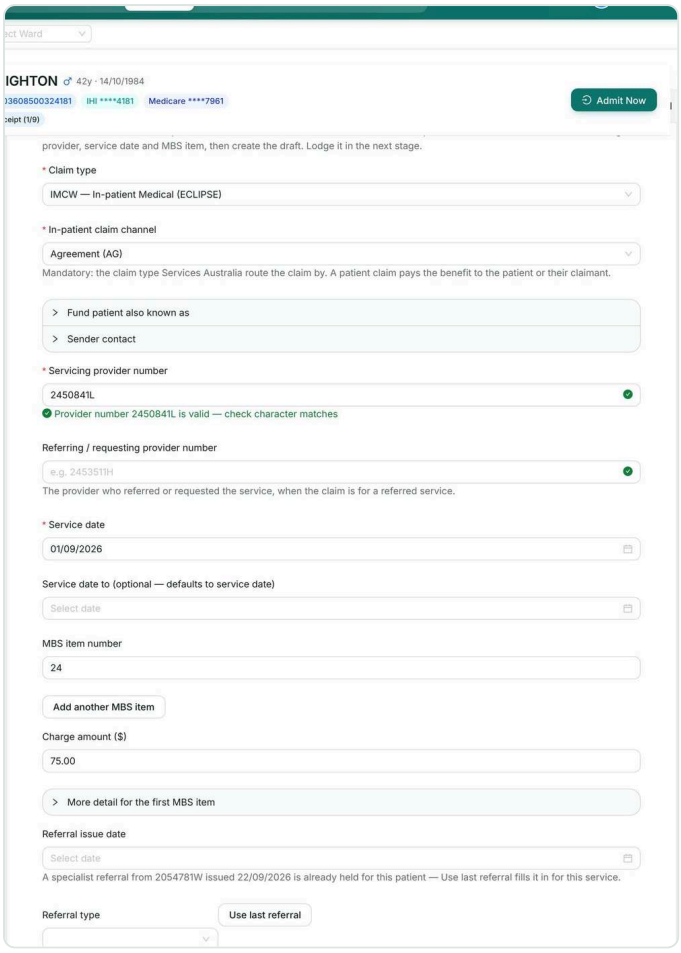
- If Medicare sends back corrected patient details with its answer, confirm them with the patient and choose **Update** or **Leave as is** (as in section 5.4).
- The fund and Medicare outcomes arrive as claim reports, and the fund's payment as a remittance advice (section 14).
- If the claim was refused, correct it and lodge again (section 15).



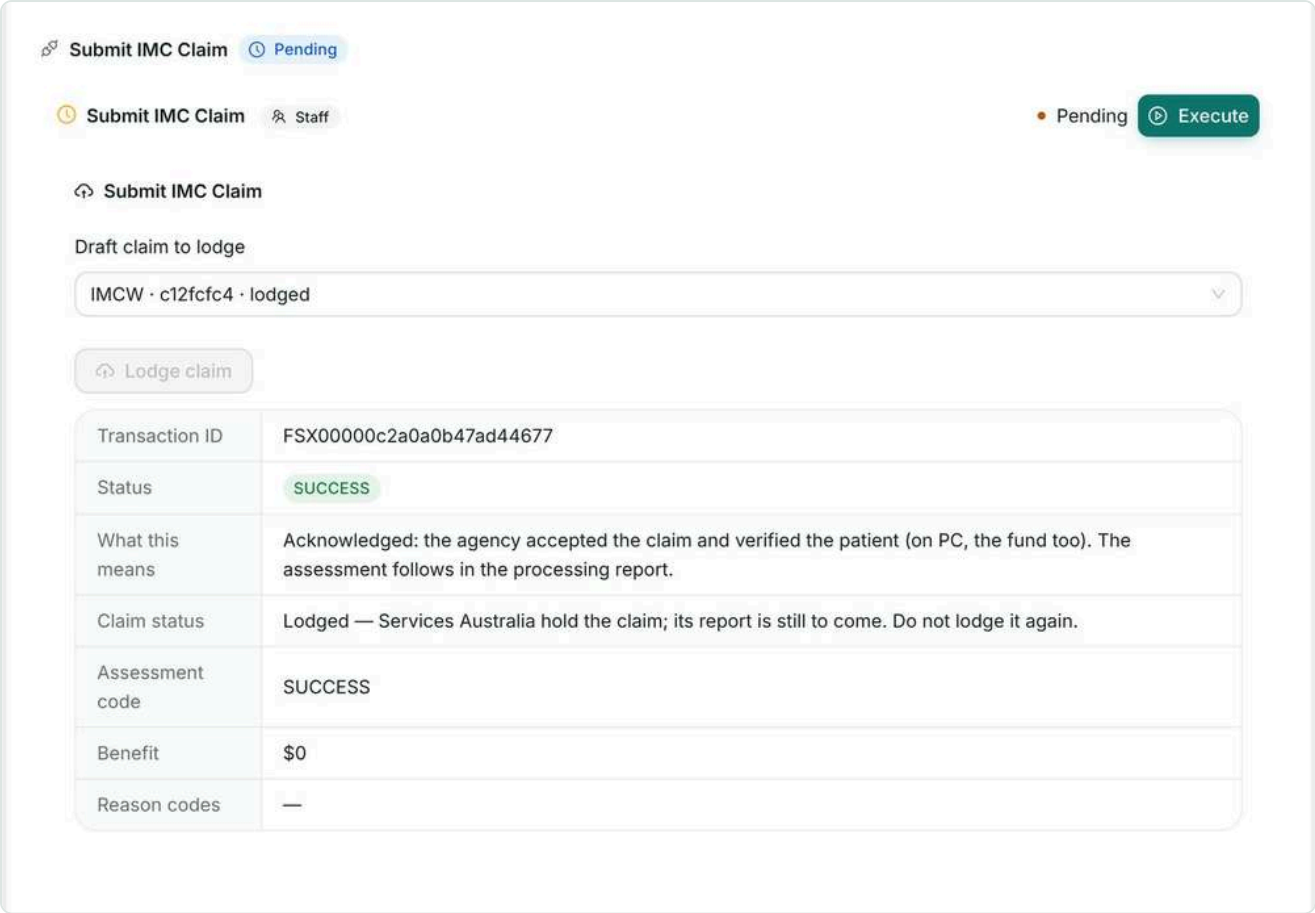
The **Coding & Grouping** stage of the Private Hospital Claiming pathway: **Code the Episode** opens coding (ICD-10-AM diagnoses and ACHI procedures), which flows into the in-hospital and in-patient medical claim drafts.



The **Draft IMC Claim** card on the Private Hospital Claiming pathway: claim type, in-patient claim channel, the fund patient's other names, sender contact, providers, service date and MBS items.



Draft IMC Claim on the System: Private Hospital Claiming (IMCW / IHCW) pathway.



Submit IMC Claim after lodgement.

SECTION 11

In-hospital claims (IHC)

An in-hospital claim sends the **hospital's own charges** (accommodation, theatre and prostheses) to the patient's health fund through ECLIPSE.

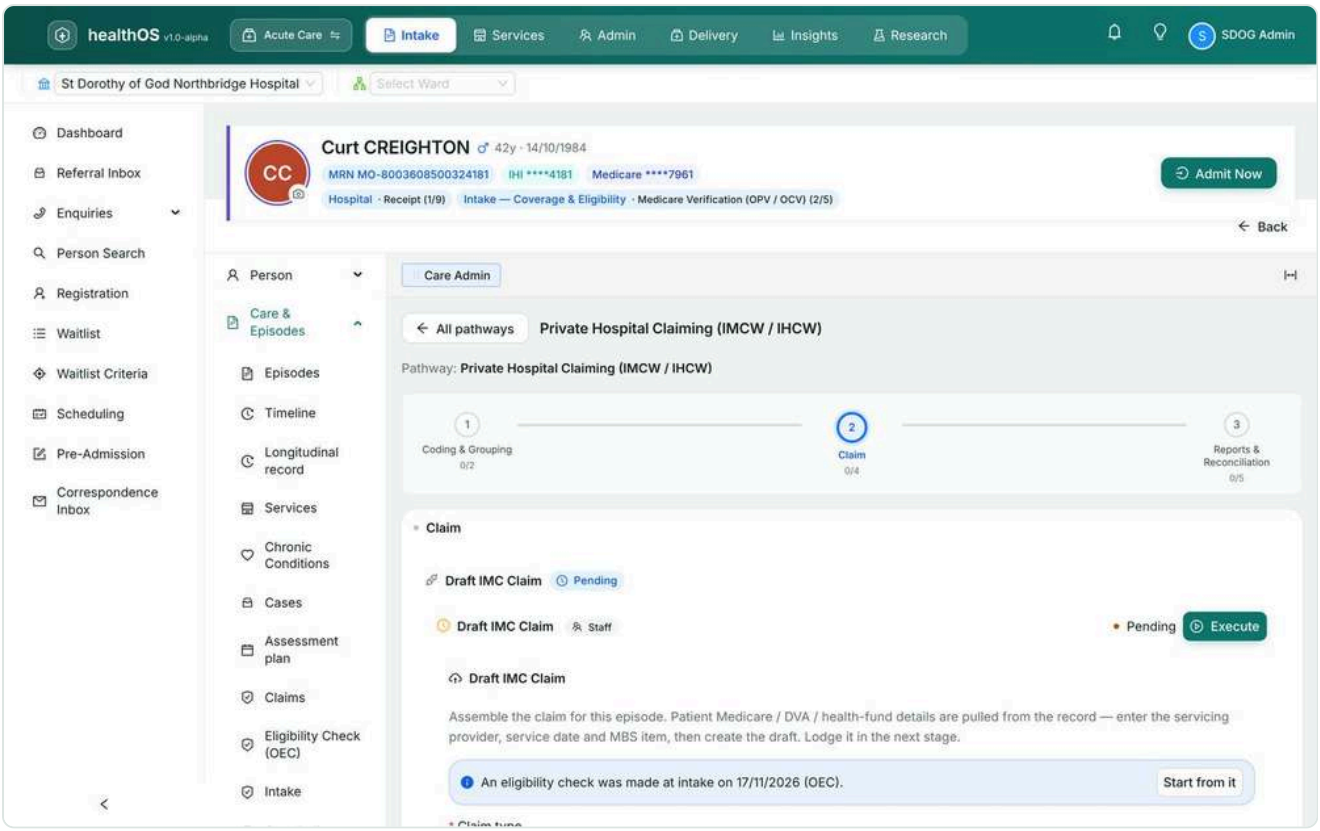
Where: patient chart → **Care Admin** → **System: Private Hospital Claiming (IMCW / IHCW)** → **Claim** stage.

Before you start: check the patient's health fund membership (section 5). For a DVA patient in a private hospital, you need the hospital's DVA **Facility ID**.

Worked example: an in-hospital claim

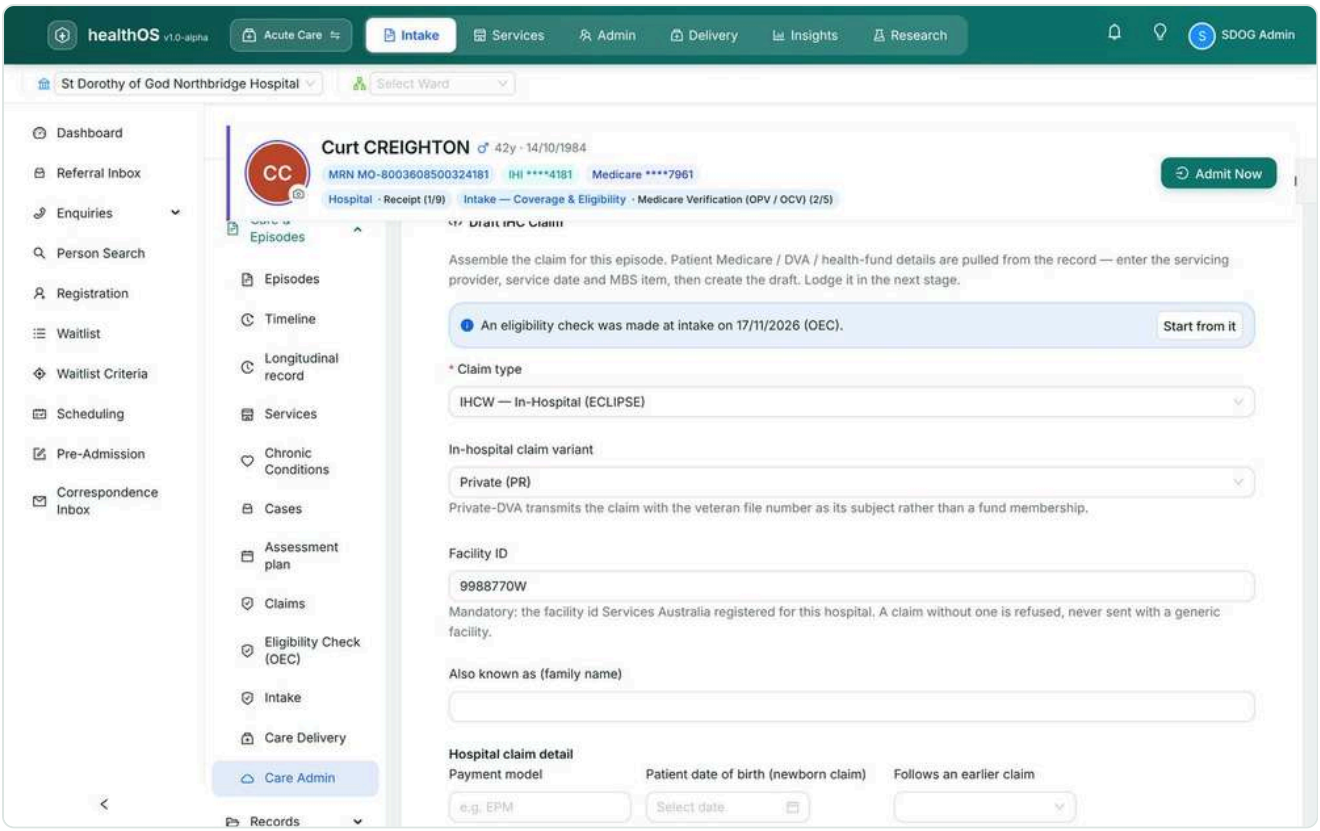
This example follows the hospital's in-hospital claim to Curt Creighton's fund for the same stay as the worked example in section 10. It was lodged in Services Australia's test environment on 17 November 2026, with Services Australia's own test patients and providers. The numbered sections after it explain each step and its options.

1. On the chart, open **Care Admin → Private Hospital Claiming (IMCW / IHCW)** at the **Claim** stage.



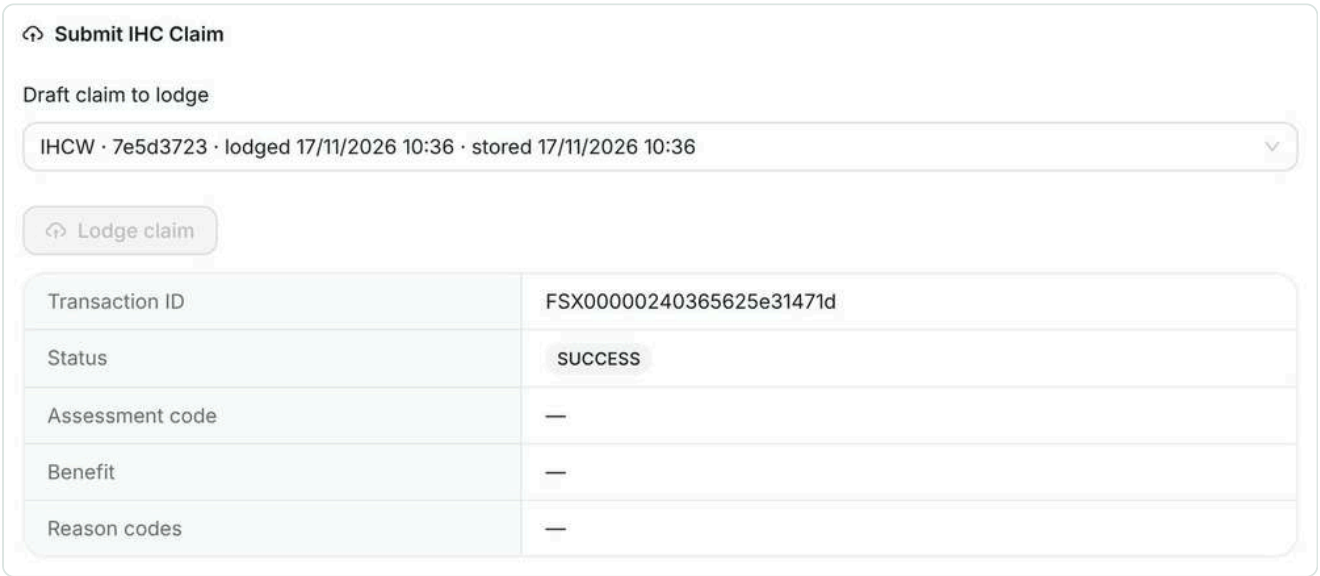
The **Private Hospital Claiming (IMCW / IHCW)** pathway at its **Claim** stage.

2. **Draft the claim.** In **Draft IHC Claim**, choose claim type **IHCW** and the variant (**Private (PR)** here), enter the hospital's **Facility ID**, and complete the hospital claim detail: the episode, accommodation, theatre and items. Choose **Create draft claim**.



Draft IHC Claim: the eligibility check made at intake, the claim type, the in-hospital claim variant and the facility ID, with the hospital claim detail below.

3. **Lodge it** in **Submit IHC Claim**. Services Australia answered **SUCCESS**; the fund's assessment and remittance advice follow (section 14).



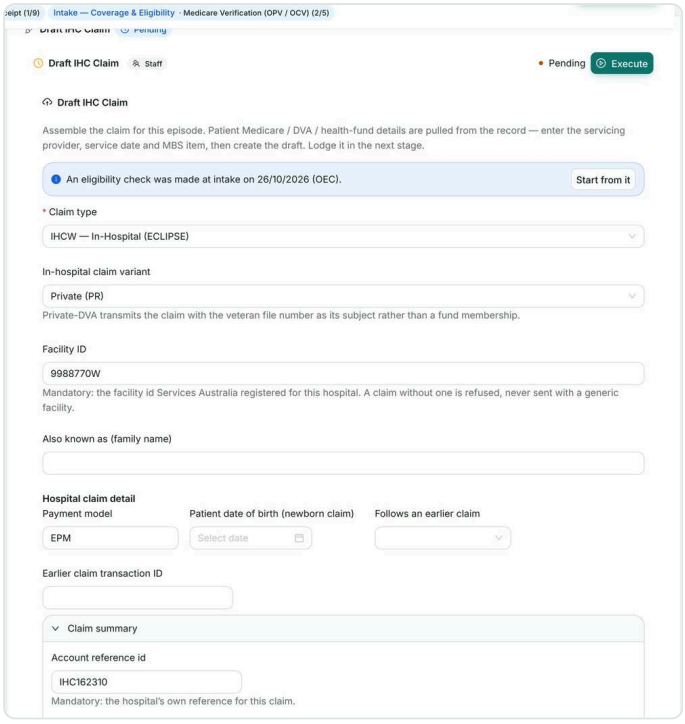
Submit IHC Claim after lodgement: the Transaction ID and the status SUCCESS.

11.1 Draft and lodge an in-hospital claim

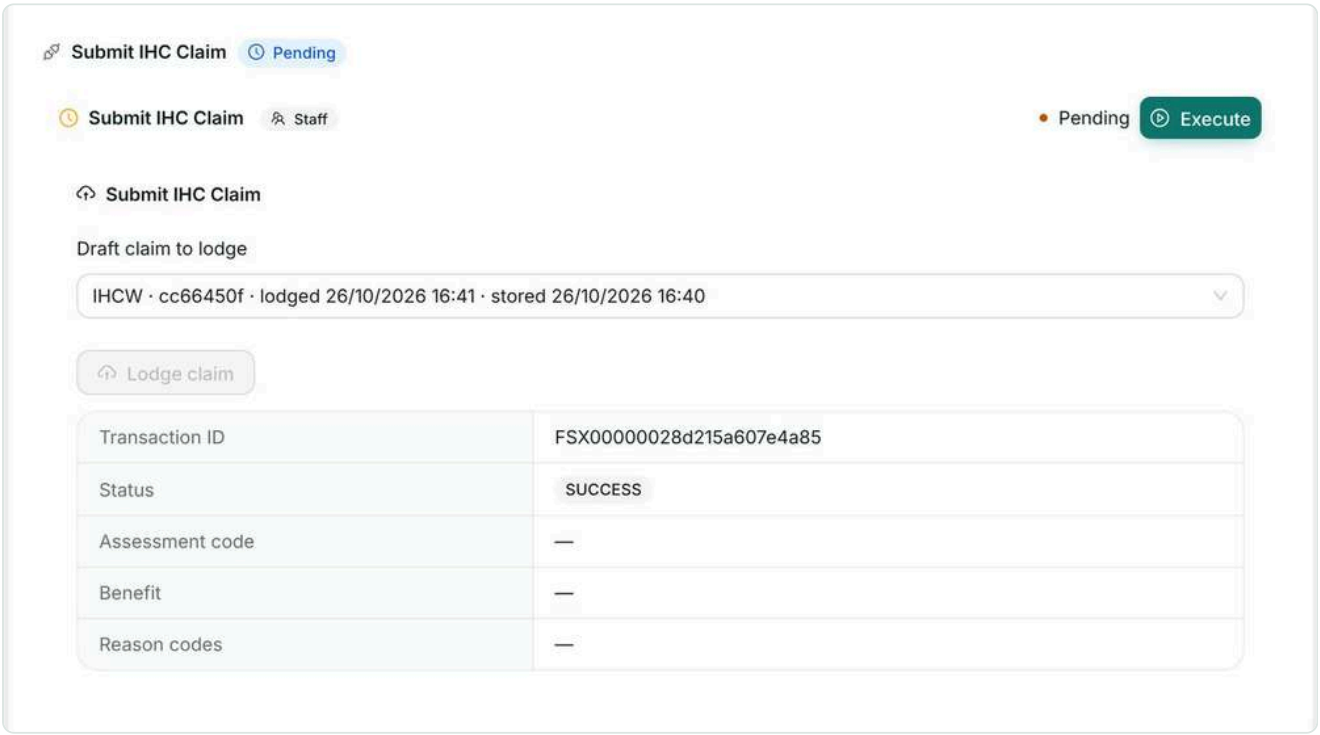
1. Open **Draft IHC Claim** and choose **IHCW**.
2. Choose the **In-hospital claim variant**: **public**, **private**, or **private-DVA**. For private-DVA, enter the DVA **Facility ID**.

3. Complete the fund details, the admission and discharge dates (leave them blank to use the episode's) and the charges.
4. Choose **Create draft claim**.
5. In **Submit IHC Claim**, select the draft and choose **Lodge claim**, then **Lodge**.

What to do next: the fund's outcome arrives as an IHC claim report and its payment as a remittance advice (section 14). If the claim was refused, correct it and lodge again (section 15). Refusal code 7013 on a private-DVA claim means the Facility ID is not linked to your location: email support (section 17).



Draft IHC Claim: the claim type and the in-hospital claim variant (public, private or private-DVA).



Submit IHC Claim after lodgement: Transaction ID and status.

SECTION 12

Overseas visitor claims (OVS)

Use an overseas claim for a patient covered by an overseas visitor's insurer instead of Medicare.

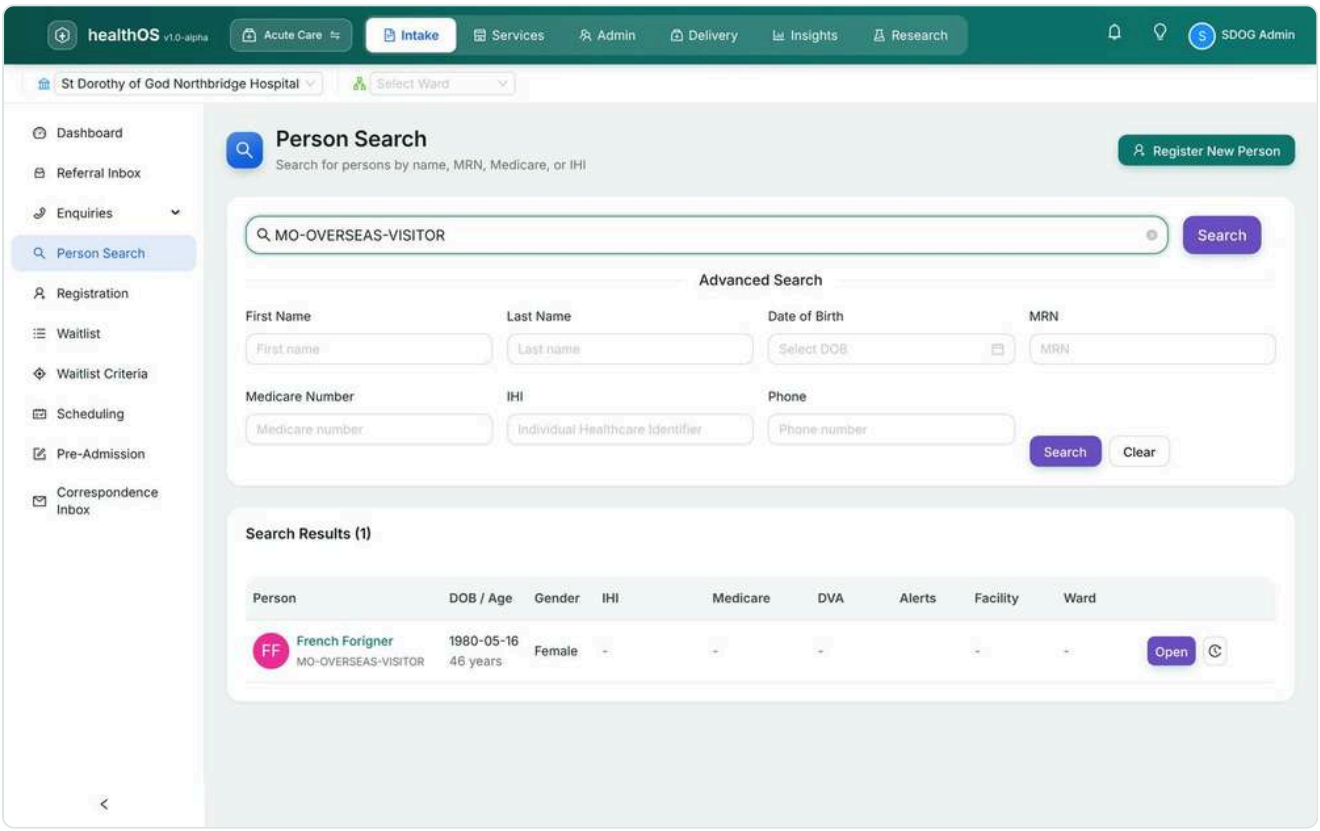
Where: patient chart → **Care Admin** → **System: Overseas Visitor Claiming (OVSW)**.

Before you start: check the visitor's cover with an **ECO** eligibility check (section 6).

Worked example: an overseas visitor from eligibility check to claim

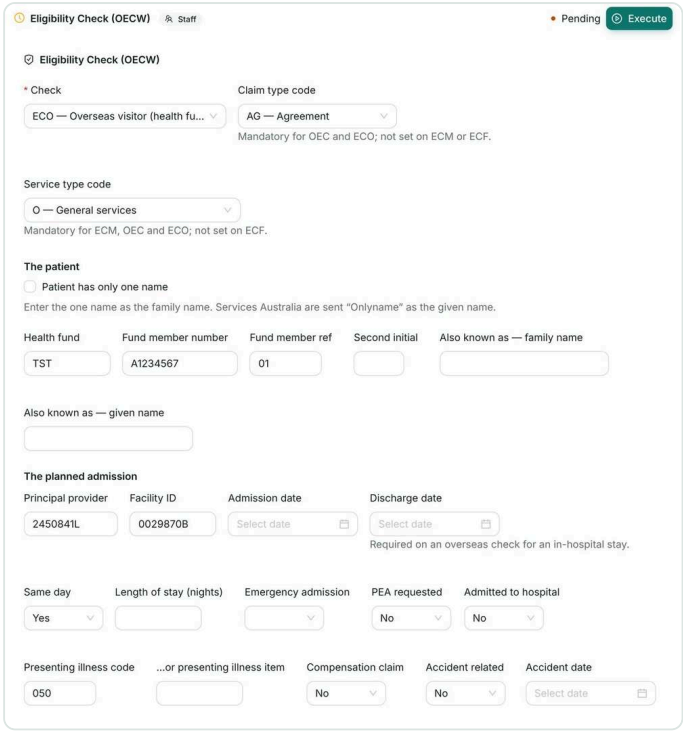
This example follows an overseas visitor with private cover through an eligibility check and an overseas claim. It was lodged in Services Australia's test environment on 17 November 2026, with Services Australia's own test patients and providers. The numbered sections after it explain each step and its options.

1. **Find the patient.** Open **Person Search**, search by MRN or name, and open the patient's chart. An overseas visitor has a health fund membership and no Medicare card.



Person Search with the overseas visitor found.

2. **Check eligibility.** Open the **Eligibility Check (OECW)**, choose the overseas check (**ECO**), and complete the fund, the planned admission and the MBS service (section 6).



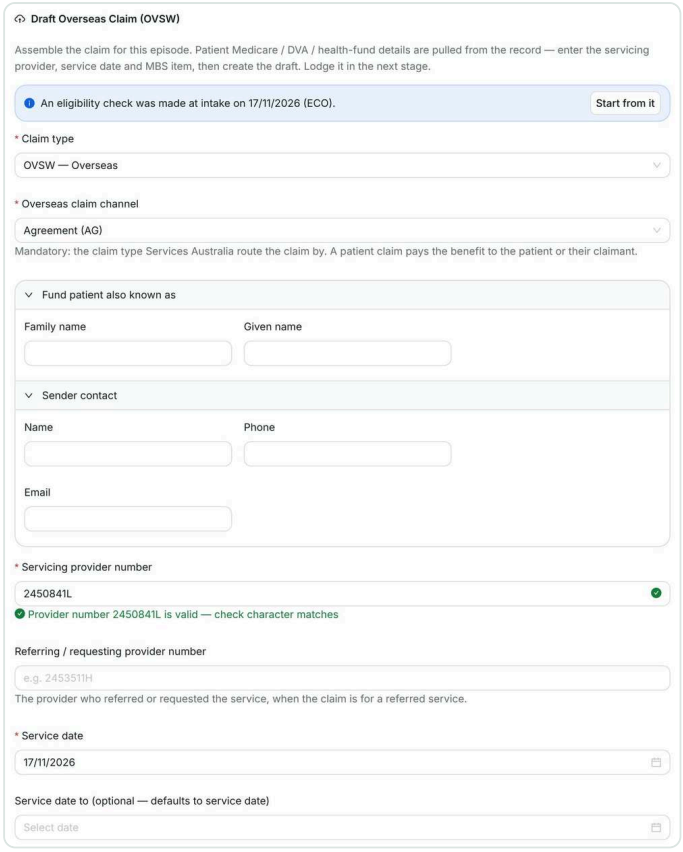
Eligibility Check (OECW) filled in for an overseas visitor: the check type, the fund membership, the planned admission and the MBS service.

3. **Read the answer.** The check came back **COMPLETE**. **OEC report** opens the printable report for informed financial consent (section 13.6).



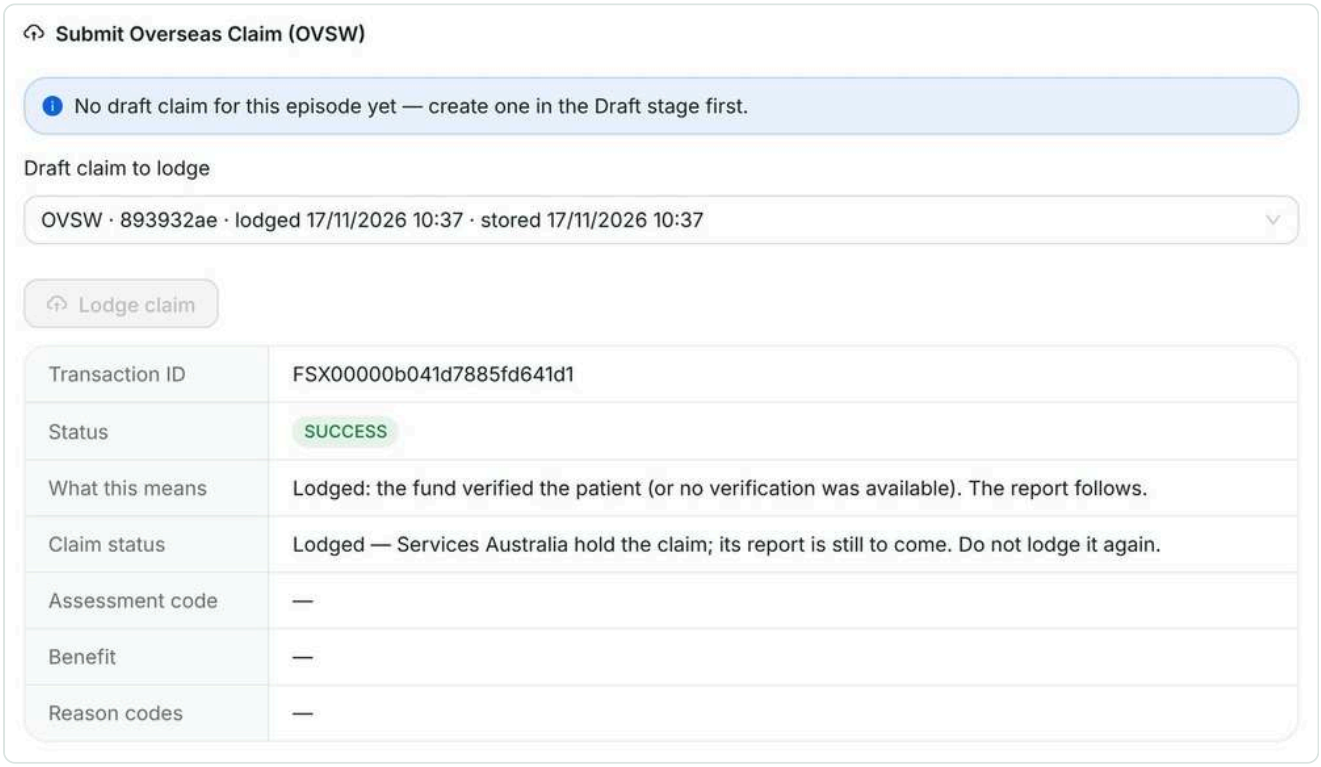
The answer: **Eligibility check complete**, status COMPLETE, with the Transaction ID and the **OEC report** button.

4. **Draft the claim.** On **Care Admin → Overseas Visitor Claiming (OVSW)**, **Claim** stage, complete **Draft Overseas Claim (OVSW)**. The check made at intake is offered with **Start from it**, which fills the claim from it. Choose **Create draft claim**.



Draft Overseas Claim (OVSW) filled in: the eligibility check offered with **Start from it**, the claim type, the channel, the providers and the service date.

5. **Lodge it** in **Submit Overseas Claim (OVSW)**. Services Australia answered **SUCCESS**: they hold the claim, and the report follows (section 14).

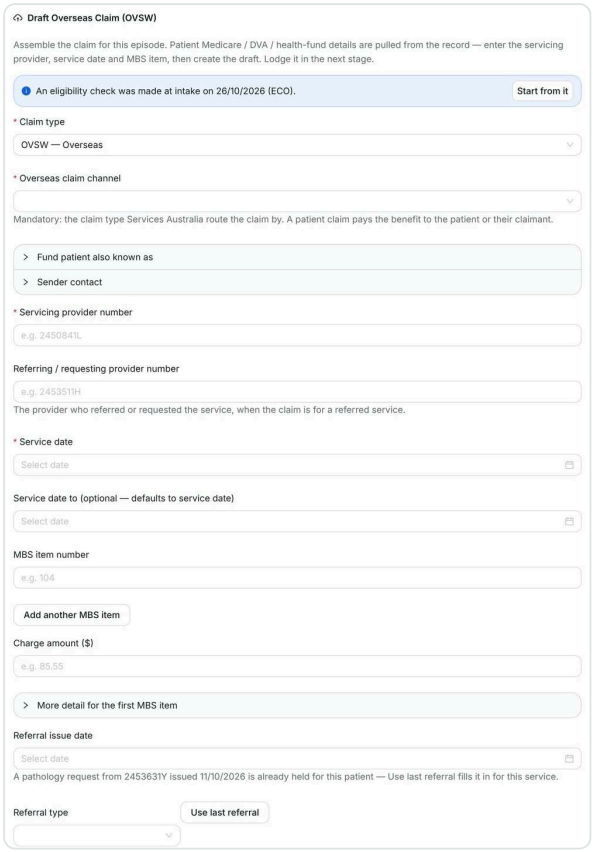


Submit Overseas Claim (OVSW) after lodgement: the Transaction ID and the status SUCCESS.

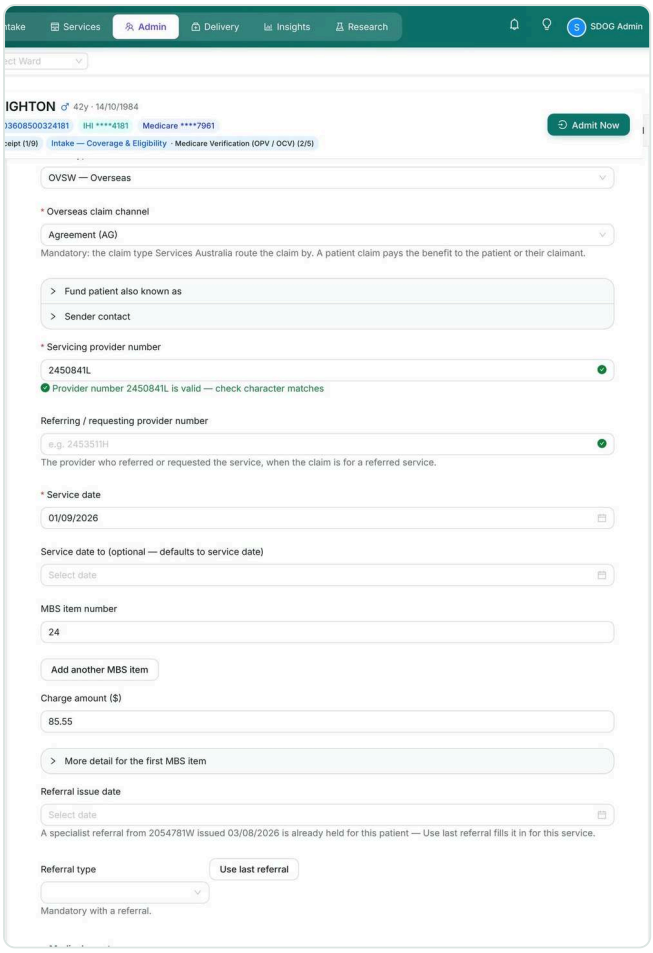
12.1 Draft and lodge an overseas claim

1. On the **Claim** stage, open **Draft Overseas Claim (OVSW)** and choose OVSW.
2. Enter the servicing provider number, service date and MBS items, and set **Account paid** (paid in full or not paid).
3. Choose **Create draft claim**. The draft is kept and can be lodged now or later. (If an ECO check was made at intake, **Start from it** fills the claim from it.)
4. In **Submit Overseas Claim (OVSW)**, select the draft and choose **Lodge claim**, then **Lodge**.

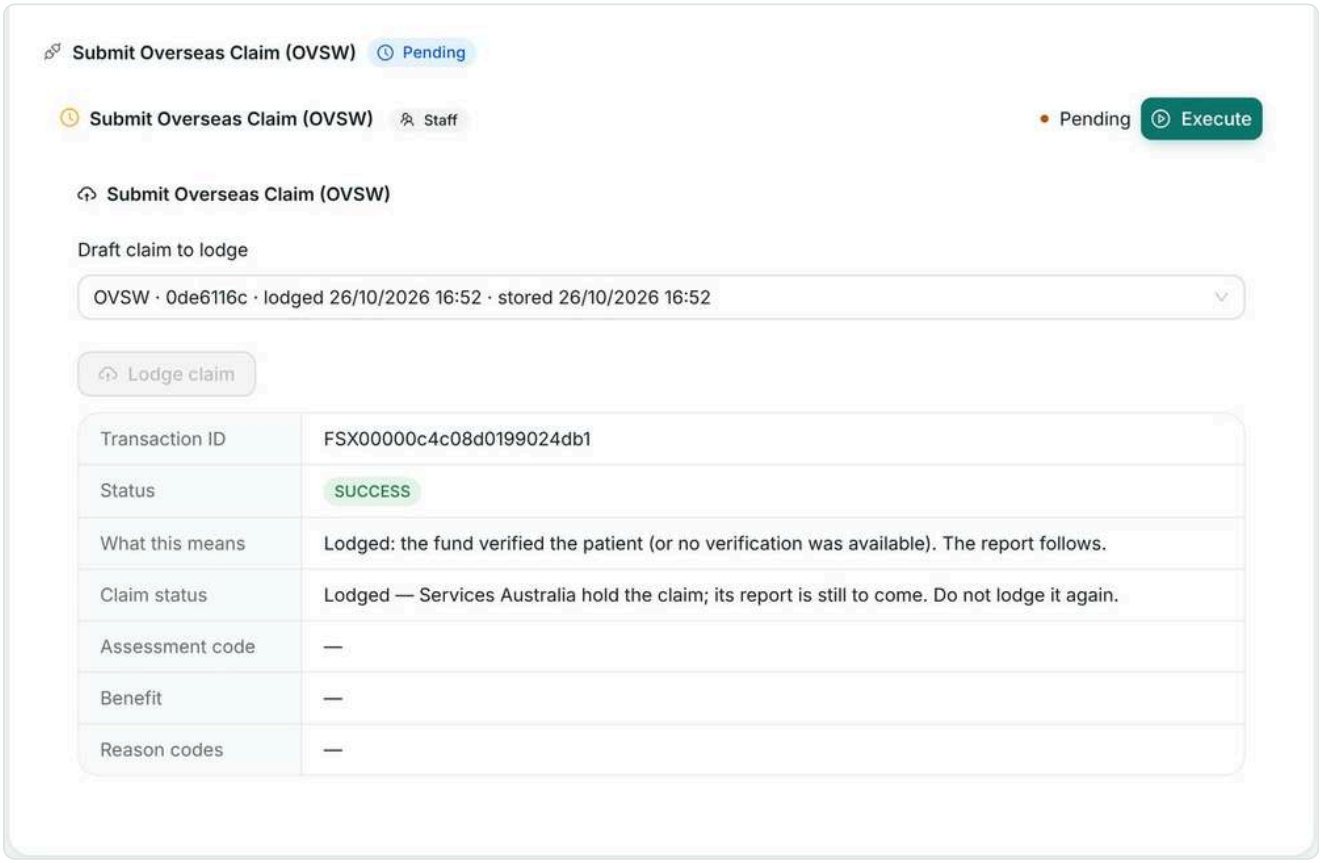
What to do next: the insurer's outcome arrives as an overseas claim report; retrieve it with **Retrieve Overseas Report** (section 14.3). If the claim was refused, correct it and lodge again (section 15).



The **Draft Overseas Claim (OVSW)** card: an eligibility check made at intake is offered with **Start from it**, then the claim type, overseas claim channel, providers, service date and MBS items.



Draft Overseas Claim (OVSW) on the System: Overseas Visitor Claiming (OVSW) pathway.



Submit Overseas Claim (OVSW) after lodgement.

SECTION 13

Documents for the patient

HealthOS produces every document from the claim, so nothing is typed by hand. Each opens in a new window, ready to print or save, from a button on the claim's Submit card at the moment it is needed. To print one again later, use **Reprint Claim Documents** on the pathway's **Reports & Reconciliation** stage, or the claim's row on **Online Claiming → Transactions**.

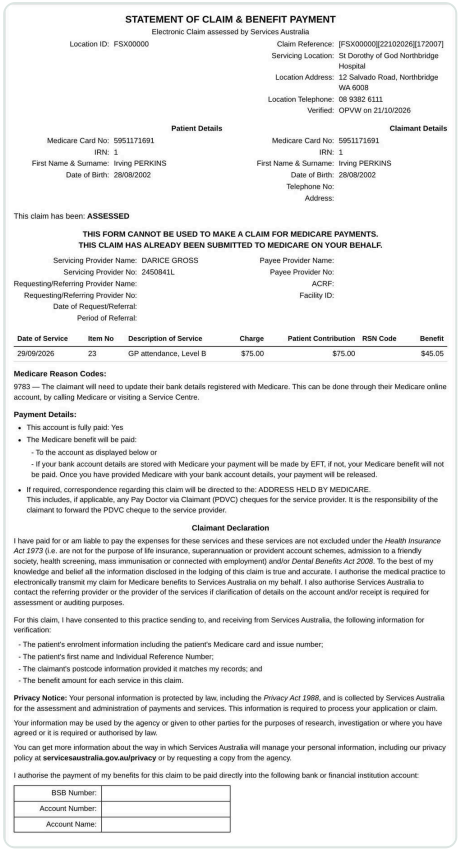
DOCUMENT	GIVEN WHEN	PRINTED FROM
Statement of Claim and Benefit	A patient claim has been assessed and a benefit worked out	Submit Patient Claim (PCIW) → **Statement of Claim & Benefit Payment**
Lodgement Advice	A patient claim has been received but not assessed (referred to Medicare, or stored)	Submit Patient Claim (PCIW) → **Lodgement Advice**
DB4 assignment of benefit	Before a bulk bill claim (and optionally after the service)	Submit Bulk Bill Claim (BBSW) → **Print the DB4 for signing** / **DB4 Assignment of Benefit (after the service)**
IMC consent and declaration	Before an in-patient medical patient claim	Submit IMC Claim → **Show the consent and declaration**
DVA claim voucher	Before a DVA claim	Submit DVA Claim → **Print the voucher for signing**
OEC report	After an eligibility check, with the financial consent	The eligibility check → **OEC report**

13.1 Statement of Claim and Benefit

The **Statement of Claim and Benefit** is given to the claimant when a **patient claim has been lodged in real time, processed by Services Australia, and a benefit amount returned**. It tells the patient what Medicare will pay. It states "This claim has been: ASSESSED" and shows:

- the patient, the claimant and the servicing provider,
- each service, with its charge, the patient's contribution, any reason code and the benefit,
- the reason codes explained in Medicare's words,
- the payment details and the claimant's declaration.

It is offered when Medicare answers MEDICARE_ASSESSED.



STATEMENT OF CLAIM & BENEFIT PAYMENT

Electronic Claim assessed by Services Australia

Location ID: FSX00000

Claim Reference: [FSX00000][22102026][172007]
Servicing Location: St Dorothy of God Northbridge Hospital
Location Address: 12 Salvado Road, Northbridge WA 6008
Location Telephone: 08 9382 6111
Verified: OPVW on 21/10/2026

Patient Details

Medicare Card No: 5951171691
IRN: 1
First Name & Surname: Irving PERKINS
Date of Birth: 28/08/2002

Claimant Details

Medicare Card No: 5951171691
IRN: 1
First Name & Surname: Irving PERKINS
Date of Birth: 28/08/2002
Telephone No:
Address:

This claim has been: **ASSESSED**

THIS FORM CANNOT BE USED TO MAKE A CLAIM FOR MEDICARE PAYMENTS.
THIS CLAIM HAS ALREADY BEEN SUBMITTED TO MEDICARE ON YOUR BEHALF.

Servicing Provider Name: DARICE GROSS
Servicing Provider No: 2450841L
Requesting/Referring Provider Name:
Requesting/Referring Provider No:
Date of Request/Referral:
Period of Referral:

Payee Provider Name:
Payee Provider No:
ACRF:
Facility ID:

Date of Service	Item No	Description of Service	Charge	Patient Contribution	RSN Code	Benefit
29/09/2026	23	GP attendance, Level B	$75.00	$75.00		$45.05

Medicare Reason Codes:

9783 — The claimant will need to update their bank details registered with Medicare. This can be done through their Medicare online account, by calling Medicare or visiting a Service Centre.

Payment Details:

- This account is fully paid: Yes
- The Medicare benefit will be paid:
  - To the account as displayed below or
  - If your bank account details are stored with Medicare your payment will be made by EFT, if not, your Medicare benefit will not be paid. Once you have provided Medicare with your bank account details, your payment will be released.
- If required, correspondence regarding this claim will be directed to the: ADDRESS HELD BY MEDICARE.
  This includes, if applicable, any Pay Doctor via Claimant (PDVC) cheques for the service provider. It is the responsibility of the claimant to forward the PDVC cheque to the service provider.

Claimant Declaration

I have paid for or am liable to pay the expenses for these services and these services are not excluded under the *Health Insurance Act 1973* (i.e. are not for the purpose of life insurance, superannuation or provident account schemes, admission to a friendly society, health screening, mass immunisation or connected with employment) and/or *Dental Benefits Act 2008*. To the best of my knowledge and belief all the information disclosed in the lodging of this claim is true and accurate. I authorise the medical practice to electronically transmit my claim for Medicare benefits to Services Australia on my behalf. I also authorise Services Australia to contact the referring provider or the provider of the services if clarification of details on the account and/or receipt is required for assessment or auditing purposes.

For this claim, I have consented to this practice sending to, and receiving from Services Australia, the following information for verification:

- The patient's enrolment information including the patient's Medicare card and issue number;
- The patient's first name and Individual Reference Number;
- The claimant's postcode information provided it matches my records; and
- The benefit amount for each service in this claim.

Privacy Notice: Your personal information is protected by law, including the *Privacy Act 1988*, and is collected by Services Australia for the assessment and administration of payments and services. This information is required to process your application or claim.

Your information may be used by the agency or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law.

You can get more information about the way in which Services Australia will manage your personal information, including our privacy policy at **servicesaustralia.gov.au/privacy** or by requesting a copy from the agency.

I authorise the payment of my benefits for this claim to be paid directly into the following bank or financial institution account:

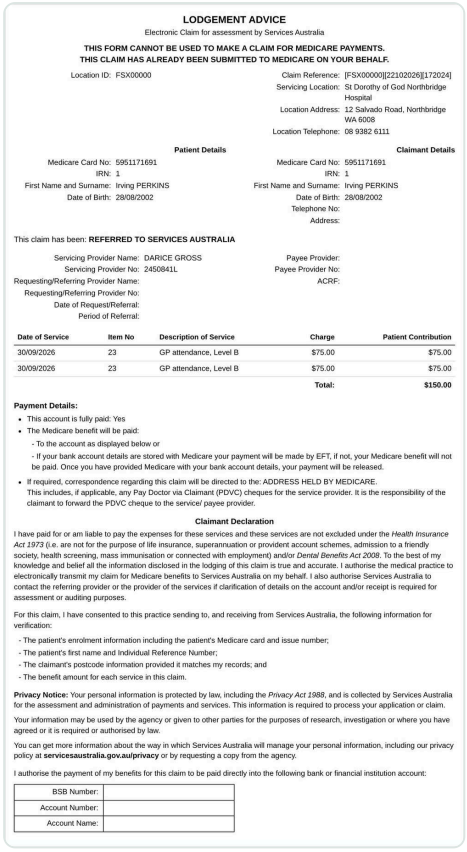
BSB Number:	
Account Number:	
Account Name:	

> Statement of Claim & Benefit Payment produced by HealthOS for an assessed patient claim, with the benefit and the Medicare reason code explained.

13.2 Lodgement Advice

The **Lodgement Advice** is given to the claimant when a **patient claim has been lodged in real time and referred to a Services Australia operator for action**, or stored to be sent later. It is the patient's proof that the claim was made. It shows **no benefit**, because none has been worked out yet. It reads "This claim has been: REFERRED TO SERVICES AUSTRALIA/STORED FOR LATER TRANSMISSION".

It is offered for any answer other than MEDICARE_ASSESSED.



LODGEMENT ADVICE

Electronic Claim for assessment by Services Australia

THIS FORM CANNOT BE USED TO MAKE A CLAIM FOR MEDICARE PAYMENTS.
THIS CLAIM HAS ALREADY BEEN SUBMITTED TO MEDICARE ON YOUR BEHALF.

Location ID: FSX00000

Claim Reference: [FSX00000][22102026][172024]
Servicing Location: St Dorothy of God Northbridge Hospital
Location Address: 12 Salvado Road, Northbridge WA 6008
Location Telephone: 08 9382 6111

Patient Details

Medicare Card No: 5951171691
IRN: 1
First Name and Surname: Irving PERKINS
Date of Birth: 28/08/2002

Claimant Details

Medicare Card No: 5951171691
IRN: 1
First Name and Surname: Irving PERKINS
Date of Birth: 28/08/2002
Telephone No:
Address:

This claim has been: **REFERRED TO SERVICES AUSTRALIA**

Servicing Provider Name: DARICE GROSS
Servicing Provider No: 2450841L
Requesting/Referring Provider Name:
Requesting/Referring Provider No:
Date of Request/Referral:
Period of Referral:

Payee Provider:
Payee Provider No:
ACRF:

Date of Service	Item No	Description of Service	Charge	Patient Contribution
30/09/2026	23	GP attendance, Level B	$75.00	$75.00
30/09/2026	23	GP attendance, Level B	$75.00	$75.00
			Total:	**$150.00**

Payment Details:

- This account is fully paid: Yes
- The Medicare benefit will be paid:
  - To the account as displayed below or
  - If your bank account details are stored with Medicare your payment will be made by EFT, if not, your Medicare benefit will not be paid. Once you have provided Medicare with your bank account details, your payment will be released.
- If required, correspondence regarding this claim will be directed to the: ADDRESS HELD BY MEDICARE.
  This includes, if applicable, any Pay Doctor via Claimant (PDVC) cheques for the service provider. It is the responsibility of the claimant to forward the PDVC cheque to the service/ payee provider.

Claimant Declaration

I have paid for or am liable to pay the expenses for these services and these services are not excluded under the *Health Insurance Act 1973* (i.e. are not for the purpose of life insurance, superannuation or provident account schemes, admission to a friendly society, health screening, mass immunisation or connected with employment) and/or *Dental Benefits Act 2008*. To the best of my knowledge and belief all the information disclosed in the lodging of this claim is true and accurate. I authorise the medical practice to electronically transmit my claim for Medicare benefits to Services Australia on my behalf. I also authorise Services Australia to contact the referring provider or the provider of the services if clarification of details on the account and/or receipt is required for assessment or auditing purposes.

For this claim, I have consented to this practice sending to, and receiving from Services Australia, the following information for verification:

- The patient's enrolment information including the patient's Medicare card and issue number;
- The patient's first name and Individual Reference Number;
- The claimant's postcode information provided it matches my records; and
- The benefit amount for each service in this claim.

Privacy Notice: Your personal information is protected by law, including the *Privacy Act 1988*, and is collected by Services Australia for the assessment and administration of payments and services. This information is required to process your application or claim.

Your information may be used by the agency or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law.

You can get more information about the way in which Services Australia will manage your personal information, including our privacy policy at **servicesaustralia.gov.au/privacy** or by requesting a copy from the agency.

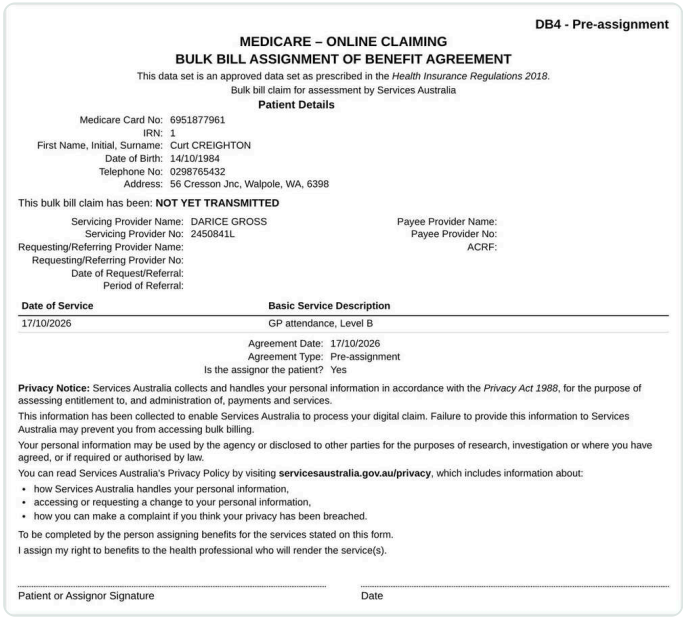
I authorise the payment of my benefits for this claim to be paid directly into the following bank or financial institution account:

BSB Number:	
Account Number:	
Account Name:	

> Lodgement Advice produced by HealthOS for a patient claim referred to Services Australia.

13.3 Bulk bill assignment of benefit (DB4)

The DB4 is the patient's agreement to assign their Medicare benefit to the provider. HealthOS prints a **pre-assignment** form, signed before the service, and a **post-assignment** form for after the service. Both carry the patient and provider details, the services, the agreement date and type, the privacy notice and the signature lines.



DB4 - Pre-assignment

MEDICARE – ONLINE CLAIMING
BULK BILL ASSIGNMENT OF BENEFIT AGREEMENT

This data set is an approved data set as prescribed in the *Health Insurance Regulations 2018*.
Bulk bill claim for assessment by Services Australia

Patient Details

Medicare Card No: 6951877961
IRN: 1
First Name, Initial, Surname: Curt CREIGHTON
Date of Birth: 14/10/1984
Telephone No: 0298765432
Address: 56 Cresson Jnc, Walpole, WA, 6398

This bulk bill claim has been: **NOT YET TRANSMITTED**

Servicing Provider Name: DARICE GROSS
Servicing Provider No: 2450841L
Requesting/Referring Provider Name:
Requesting/Referring Provider No:
Date of Request/Referral:
Period of Referral:

Payee Provider Name:
Payee Provider No:
ACRF:

Date of Service	Basic Service Description
17/10/2026	GP attendance, Level B

Agreement Date: 17/10/2026
Agreement Type: Pre-assignment
Is the assignor the patient? Yes

Privacy Notice: Services Australia collects and handles your personal information in accordance with the *Privacy Act 1988*, for the purpose of assessing entitlement to, and administration of, payments and services.

This information has been collected to enable Services Australia to process your digital claim. Failure to provide this information to Services Australia may prevent you from accessing bulk billing.

Your personal information may be used by the agency or disclosed to other parties for the purposes of research, investigation or where you have agreed, or if required or authorised by law.

You can read Services Australia's Privacy Policy by visiting **servicesaustralia.gov.au/privacy**, which includes information about:

- how Services Australia handles your personal information,
- accessing or requesting a change to your personal information,
- how you can make a complaint if you think your privacy has been breached.

To be completed by the person assigning benefits for the services stated on this form.

I assign my right to benefits to the health professional who will render the service(s).

Patient or Assignor Signature

Date

> DB4 – Pre-assignment: Medicare Online Claiming Bulk Bill Assignment of Benefit Agreement as printed by HealthOS.

13.4 In-patient medical claim consent and declaration

For an in-patient medical claim made as a patient claim, the patient reads and agrees to the **In-Patient Medical Claim — Patient Claim Consent and Declaration** before the claim is lodged.



IMCW Patient Claim Consent and Declaration

Patient Details

Medicare Card No: 6951877961
IRN: 1
First Name and Surname: Curt CREIGHTON
Date of Birth: 14/10/1984

Admission Details

Admission Date: 26/10/2026
Discharge Date: 26/10/2026
Servicing Provider No: 2450841L

Service(s)

Date of Service	Item No	Description of Service	Charge	Patient Contribution
26/10/2026	30187	MBS item 30187 FacilityId-0029870B	$307.60	$307.60
			Total:	**$307.60**

I have paid for, or am liable to pay for, or the patient has paid for or is liable to pay for, the expenses for these services which are not excluded under the *Health Insurance Act 1973* (i.e. not for the purpose of life insurance, superannuation or provident account schemes, admission to a friendly society, health screening, mass immunisation or connected with employment).

To the best of my knowledge and belief all the information in this claim is true and all information disclosed by me to the medical practice in the lodging of this claim is true and accurate.

I authorise or have the patient's consent to authorise this medical practice to electronically transmit this claim for Medicare benefits (including banking details to Services Australia and for Services Australia to on forward the claim details to the nominated health fund on my behalf or the patient's behalf.

I also authorise or have the patient's consent to authorise Services Australia or the health fund to contact the referring practitioner or the provider of the services if clarification of details for this account and/or receipt is required for assessment or auditing purposes.

For this claim, I consent to or have the patient's consent to this medical practice sending to and /or receiving from Services Australia and/or the nominated health fund, the following information for the purpose of verification and /or processing this Claim:

- Patient's Medicare enrolment information (including Medicare number, issue number and individual reference number) and
- Patient's first name, family name and date of birth,
- Patient's health fund information including the patient's membership number or membership card number.

If Services Australia pays a total benefit of zero for each service within this claim, the whole claim will not be forwarded to the nominated health fund.

I acknowledge that it is a serious criminal offence to give Services Australia false or misleading information in relation to a Medicare claim.

Privacy Notice: Your personal information is protected by law, including the *Privacy Act 1988*, and is collected by Services Australia for the assessment and administration of payments and services. This information is required to process your application or claim.

Your information may be used by the agency or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law.

You can get more information about the way in which Services Australia will manage your personal information, including our privacy policy at **servicesaustralia.gov.au/privacy** or by requesting a copy from the agency.

Information about medical expense totals may also be disclosed to other authorised family members for taxation statement purposes and the monitoring of family safety net entitlements. Patient name and address details may be disclosed to financial institutions when the claim is paid.

Signature of Patient / Representative

Date

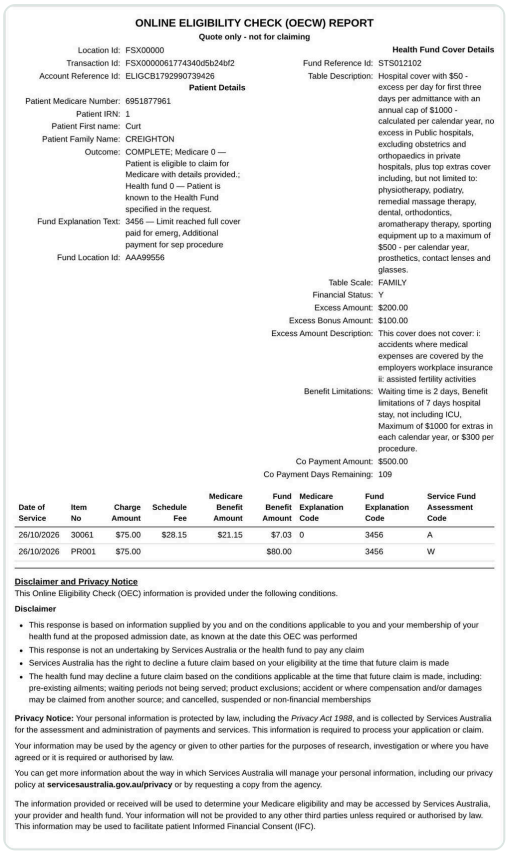
IMC Patient Claim Consent and Declaration.

13.5 DVA claim voucher

For a DVA claim, the veteran signs the DVA claim voucher for the service type before the claim is lodged.

13.6 Eligibility check (OEC) report

The **OEC report** shows the patient what Medicare and the fund would pay for each item, for their informed financial consent. It is marked "Quote only — not for claiming" and carries Services Australia's disclaimer and privacy notice.



ONLINE ELIGIBILITY CHECK (OECW) REPORT

Quote only - not for claiming

Location Id: FSX00000
Transaction Id: FSX0000061774340d5b24bf2
Account Reference Id: ELIGCB1792990739426

Patient Details

Patient Medicare Number: 6951877961
Patient IRN: 1
Patient First name: Curt
Patient Family Name: CREIGHTON
Outcome: COMPLETE; Medicare 0 — Patient is eligible to claim for Medicare with details provided.; Health fund 0 — Patient is known to the Health Fund specified in the request.
Fund Explanation Text: 3456 — Limit reached full cover paid for emerg, Additional payment for sep procedure
Fund Location Id: AAA99556

Health Fund Cover Details

Fund Reference Id: STS012102
Table Description: Hospital cover with $50 - excess per day for first three days per admittance with an annual cap of $1000 - calculated per calendar year, no excess in Public hospitals, excluding obstetrics and orthopaedics in private hospitals, plus top extras cover including, but not limited to: physiotherapy, podiatry, remedial massage therapy, dental, orthodontics, aromatherapy therapy, sporting equipment up to a maximum of $500 - per calendar year, prosthetics, contact lenses and glasses.
Table Scale: FAMILY
Financial Status: Y
Excess Amount: $200.00
Excess Bonus Amount: $100.00
Excess Amount Description: This cover does not cover: i: accidents where medical expenses are covered by the employers workplace insurance ii: assisted fertility activities
Benefit Limitations: Waiting time is 2 days, Benefit limitations of 7 days hospital stay, not including ICU, Maximum of $1000 for extras in each calendar year, or $300 per procedure.
Co Payment Amount: $500.00
Co Payment Days Remaining: 109

Date of Service	Item No	Charge Amount	Schedule Fee	Medicare Benefit Amount	Fund Benefit Amount	Medicare Explanation Code	Fund Explanation Code	Service Fund Assessment Code
26/10/2026	30061	$75.00	$28.15	$21.15	$7.03	0	3456	A
26/10/2026	PR001	$75.00			$80.00		3456	W

Disclaimer and Privacy Notice

This Online Eligibility Check (OEC) information is provided under the following conditions.

Disclaimer

- This response is based on information supplied by you and on the conditions applicable to you and your membership of your health fund at the proposed admission date, as known at the date this OEC was performed
- This response is not an undertaking by Services Australia or the health fund to pay any claim
- Services Australia has the right to decline a future claim based on your eligibility at the time that future claim is made
- The health fund may decline a future claim based on the conditions applicable at the time that future claim is made, including: pre-existing ailments; waiting periods not being served; product exclusions; accident or where compensation and/or damages may be claimed from another source; and cancelled, suspended or non-financial memberships

Privacy Notice: Your personal information is protected by law, including the *Privacy Act 1988*, and is collected by Services Australia for the assessment and administration of payments and services. This information is required to process your application or claim.

Your information may be used by the agency or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law.

You can get more information about the way in which Services Australia will manage your personal information, including our privacy policy at **servicesaustralia.gov.au/privacy** or by requesting a copy from the agency.

The information provided or received will be used to determine your Medicare eligibility and may be accessed by Services Australia, your provider and health fund. Your information will not be provided to any other third parties unless required or authorised by law. This information may be used to facilitate patient Informed Financial Consent (IFC).

> Online Eligibility Check (OECW) report with the disclaimer and privacy notice.

SECTION 14

Reports, report retrieval and reconciliation

Lodging a claim and being paid are separate events, usually a day or more apart. Medicare and DVA assess bulk bill and DVA claims overnight, and health funds pay in batches. Reports are how you find out what happened to each claim and match payments to claims.

14.1 You usually don't need to ask

HealthOS collects reports by itself:

- **Every morning** it asks Medicare and DVA for the processing and payment reports of every bulk bill and DVA claim still waiting for an outcome, and records the outcome on each claim.
- **Every hour** it collects health fund remittance advices and matches them to claims.

So when you look in the morning, the outcome is normally already there. Retrieve a report yourself (14.3) only when you want one sooner, or for a particular claim.

14.2 Which report tells you what

REPORT	TELLS YOU
Bulk bill processing report	What Medicare decided for each service: paid, reduced or rejected, with reasons
Bulk bill payment report	What was paid and when. Match the bank deposit against it
DVA processing / payment report	The same for DVA claims
Transmission status report	Whether each claim's report is ready yet
IMC, IHC and overseas claim reports	The fund's (and Medicare's) outcome of in-patient, in-hospital and overseas claims
Remittance advice (ERA)	What a health fund paid, against which claims
Bulk Bill Integrated report	The bulk bill report for a given transaction and payee provider

14.3 Retrieve a report for one patient's claim

On the claim's pathway, open the **Reports & Reconciliation** stage.

Claim Reports lists the latest report for each of this patient's lodged claims, and can fetch any that are outstanding. That is usually all you need.

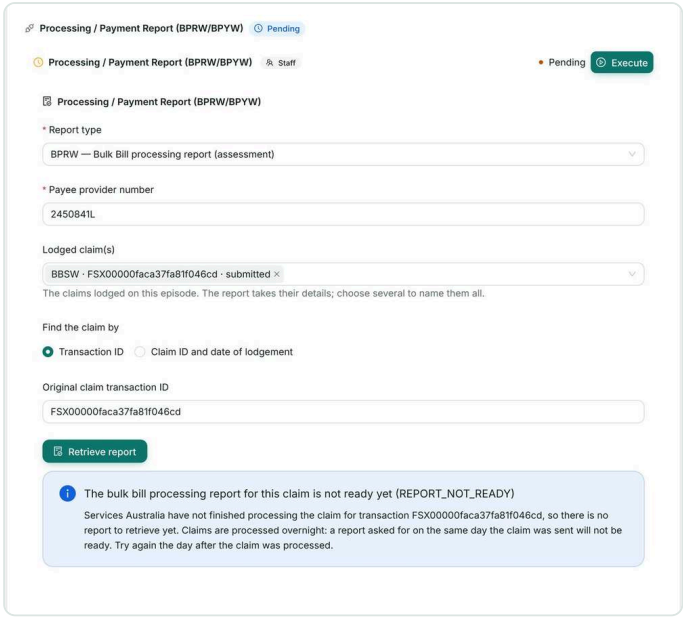
To ask for a particular report, use **Processing / Payment Report (BPRW/BPYW)**, **DVA Processing / Payment Report (DVRW/DVYW)**, **Retrieve IMC / IHC Report**, **Retrieve Overseas Report** or **Retrieve Claim Report**:

1. Choose the **Report type**, for example BPRW — Bulk Bill processing report, BPYW — Bulk Bill payment report, DVRW / DVYW — DVA processing / payment report, IMC / IHC / OVS — the claim report, or STSW — Transmission status report.
2. For a processing or payment report, choose the claim under **Lodged claim(s)** and check the **Payee provider number**. (For a claim lodged outside HealthOS, choose **Find the claim by** → **Claim ID and date of lodgement**.)
3. For a status report, you can narrow it by **Transmission type**, **Report status**, **Associate name** and **Date from / Date to**.
4. Choose **Retrieve report**.

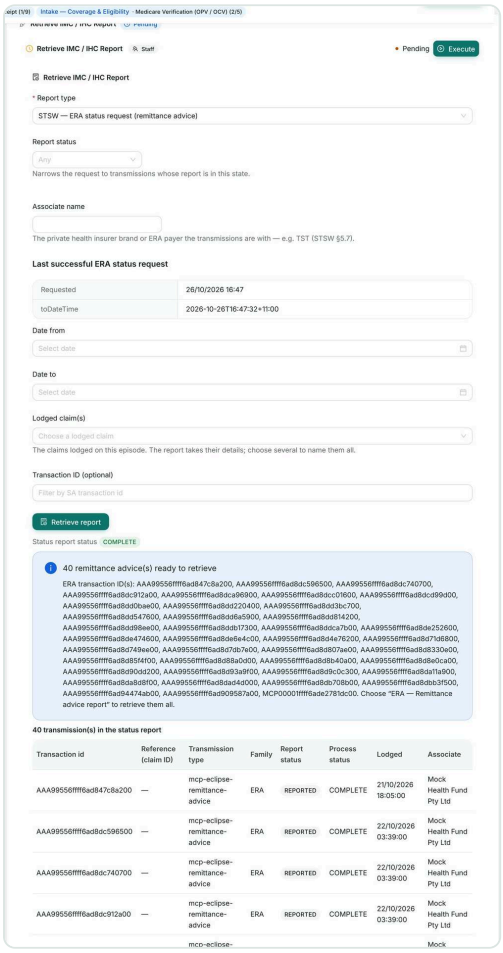
What you'll see: for each claim, its status, assessment, benefit and services. **Services Australia's payload** shows exactly what came back. The answer is one of three:

ANSWER	IT MEANS	WHAT TO DO
A report	The outcome, now recorded on the claim	Read it. Fix any rejected service (section 15.3)
REPORT_NOT_READY	Not processed yet, which is normal on the day of lodgement	Nothing; HealthOS asks again the next morning
No report available	Processing has finished and there is nothing to report	Nothing

Tip: a status report (STSW) filtered to **READY** tells you which reports can be collected now. The **Bulk Bill Integrated Report (BIRW)** card takes a transaction id and payee provider number.



Processing / Payment Report (BPRW/BPYW): the report type, payee provider number and lodged claim chosen, and Services Australia's answer for the transaction (here REPORT_NOT_READY on the day of lodgement).



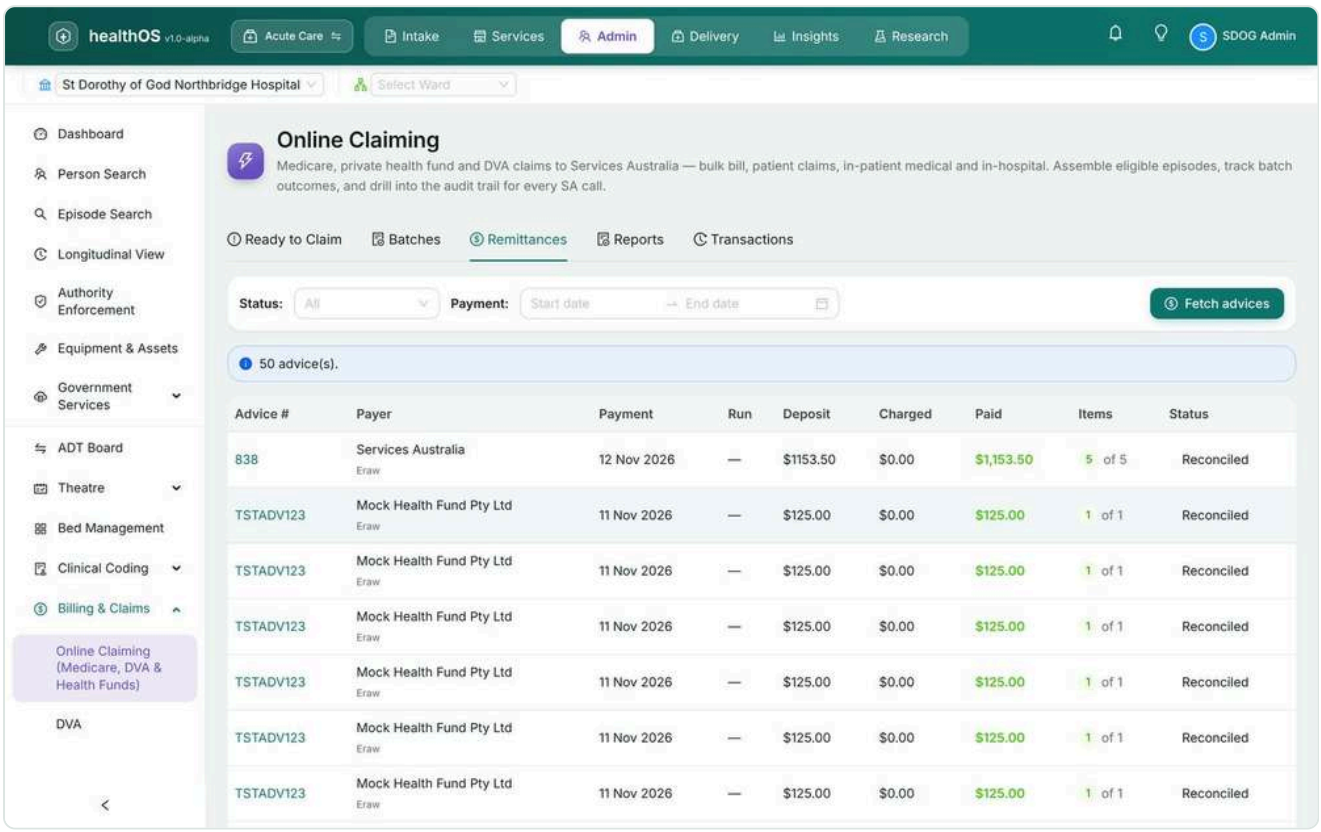
STSW — ERA status request: the last successful ERA status request and the transmissions listed with their report status.

14.4 Health fund payments (Remittances)

1. Open **PAS → Billing & Claims → Online Claiming → Remittances**.

2. Choose **Fetch advices** to collect any not yet collected. Each advice is listed with its payer, date, and the number of lines **Matched** and **Unmatched**.
3. Open an advice to see it line by line: advice number, payer, advice and payment dates, status, and totals charged and paid.

A **matched** line has already marked its claim paid, with the amount and payment run. An **unmatched** line is listed on its own for you to work by hand (14.7).

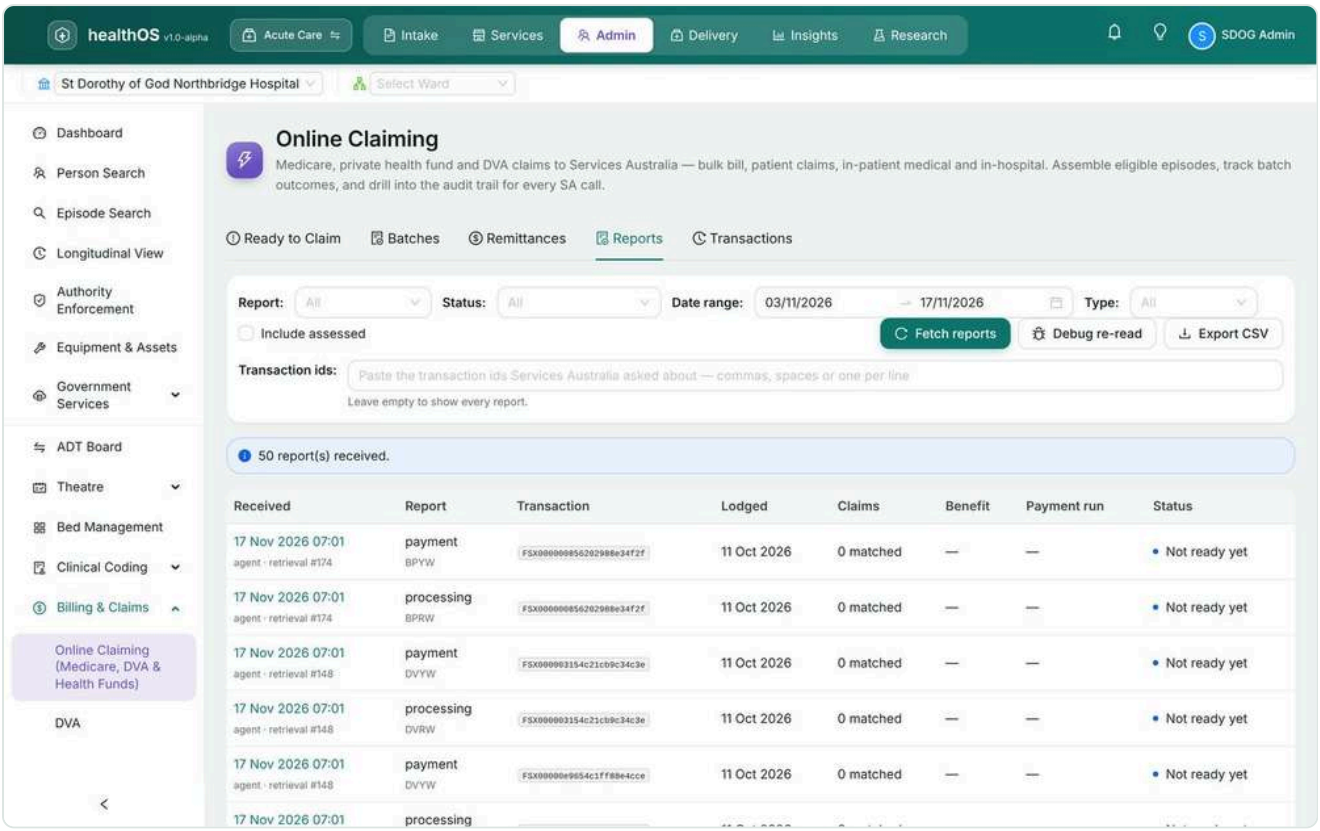


> **Online Claiming → Remittances**: each remittance advice with its payer, payment date, deposit, amounts and how many lines matched, and **Fetch advices**.

14.5 All reports, across all patients (Reports)

Online Claiming → Reports lists every processing and payment report HealthOS holds.

- Filter by **report kind** (Processing or Payment), status and date range, or paste a list of **transaction ids**.
- To collect outstanding reports now, choose the date range and, if you like, the claim family (Bulk bill, DVA medical, DVA allied), then **Fetch reports**.
- Open a report to see each service: item, service date, assessment, explanation, charge and benefit.
- **Export CSV** downloads the lines as a spreadsheet.



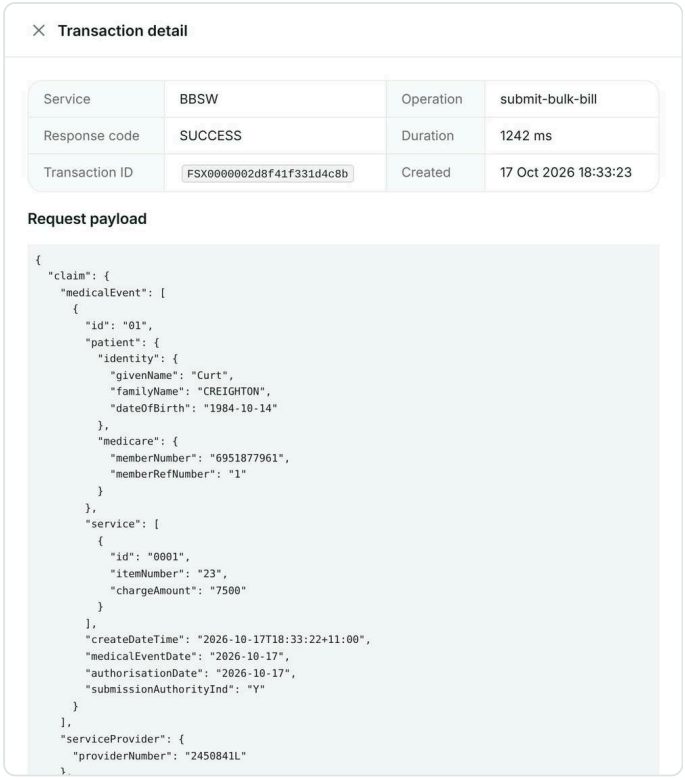
> **Online Claiming → Reports**: every processing and payment report HealthOS has collected, filtered by report, status, dates, type and transaction id, with **Fetch reports** and **Export CSV**.

The morning check: filter to yesterday's processing reports and look for services that were reduced or rejected. Each shows its reason, and section 15 explains how to fix it.

14.6 Every call to Services Australia (Transactions)

Online Claiming → Transactions lists every call HealthOS has made to Services Australia: when, which service, the result **Code**, the patient and how long it took. Filter by operation, response code, transaction id and date, or **Export CSV**.

Detail opens a transaction with exactly what was sent and what came back, which is what support will ask for. Where they apply, the row also offers **Retry** (section 15.2), **Accept for assessment** (section 8.4), the claim's documents (**Lodgement advice**, **Statement of claim**, **DB4 (pre-assignment)**, **DB4 (post-assignment)**, the DVA voucher and the IMC consent).



Transaction detail: service BBSW, operation submit-bulk-bill, response code SUCCESS, the Transaction ID, and the request payload sent to Services Australia.

14.7 Reconciling payments

1. Take the payment report (bulk bill or DVA) or the remittance advice that covers the bank deposit.
2. Match each line to its claim. Remittance advices are matched for you (14.4). For Medicare and DVA, filter **Reports** to the payment run, or export it and compare it with the bank statement.
3. Work through anything unmatched. The usual causes are a different payee provider number, or a claim lodged before your organisation used HealthOS.
4. A reduced or rejected service keeps its reason code and Medicare's wording. Either write it off, or correct it and lodge it again (section 15).

SECTION 15

Resubmitting rejected services

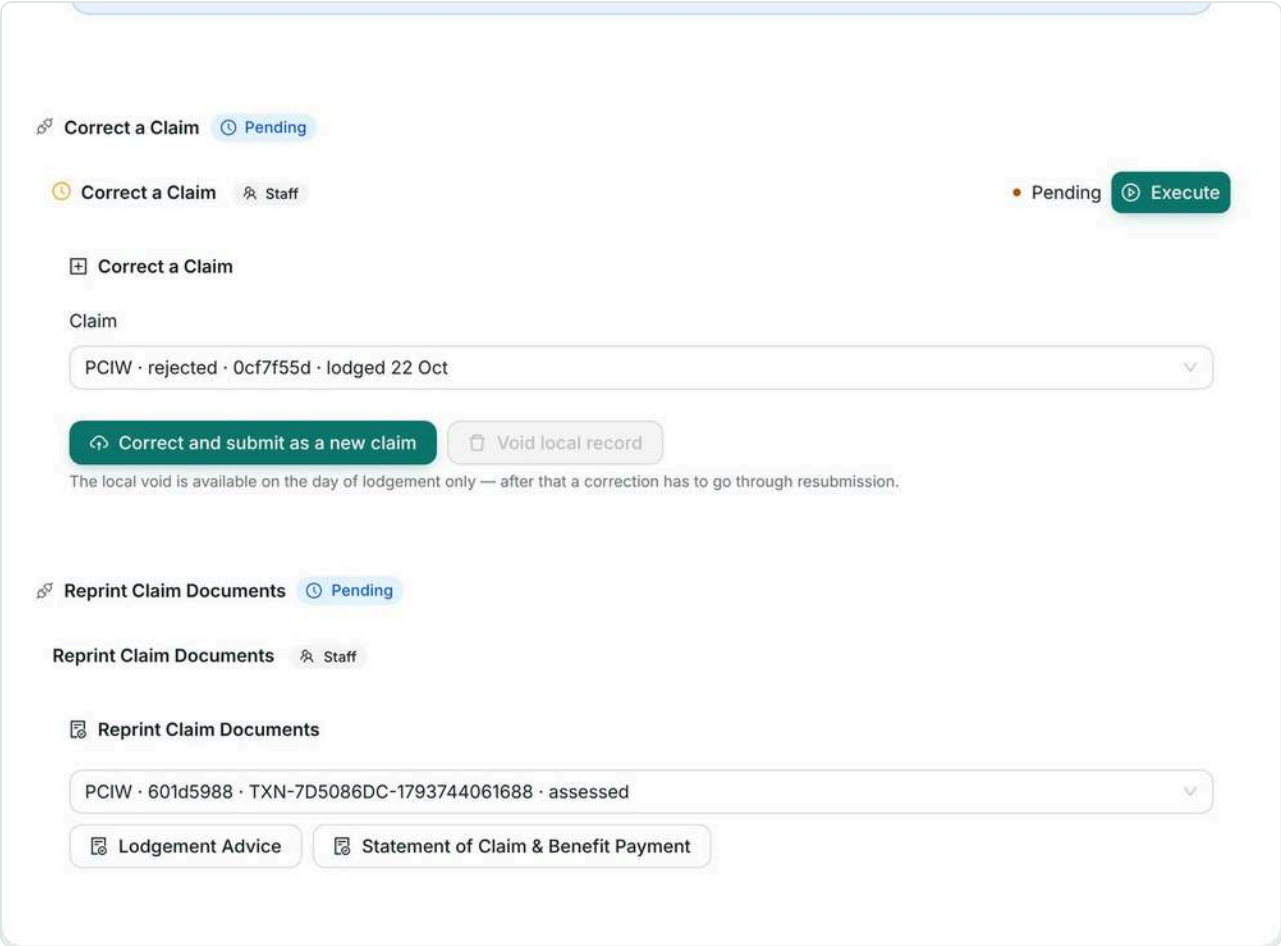
A rejected or failed claim has not been paid, so you can correct it and lodge it again. You do not need to start a new claim, and the first attempt stays on record.

15.1 Correct and resubmit a claim from its pathway

1. On the claim's pathway, open **Reports & Reconciliation** → **Correct a Claim**.
2. Choose the claim. Only claims that were **rejected** or **failed** are offered.
3. Read **Why it was rejected**. This is the reason Services Australia gave (section 17 explains the common ones).

4. Correct what the reason names: the patient's details, a provider number, an item, the referral.
5. Lodge it again. For a **patient claim**, choose **Correct and submit as a new claim** and confirm **Submit as new claim**: it is lodged as a new claim with a new Transaction ID. For any other claim, choose **Resubmit to Services Australia** and confirm.

The first attempt stays on record either way.



Correct a Claim and **Reprint Claim Documents** on the Patient Claiming pathway's Reports & Reconciliation stage: choose the rejected claim, then **Correct and submit as a new claim**. The claim documents can be reprinted at any time.

Void locally removes a claim from HealthOS's own records on the day it was lodged. It does **not** withdraw it at Services Australia. To withdraw a patient claim there, use same-day delete (section 8.6).

15.2 Retry from the Transactions list

1. Open **Online Claiming → Transactions** and find the rejected or failed submission (its **Code** is not SUCCESS or 000). **Detail** shows Services Australia's answer.
2. Correct the claim on its pathway.
3. Choose **Retry** and confirm **Retry this claim?** The claim is sent again from the corrected record, and the new attempt is listed separately.

Retry is not offered for a claim that succeeded, for checks, or for a pendable patient claim (use **Accept for assessment** for that, section 8.4).

15.3 One service rejected in a processing report

When a processing report rejects one service of a claim, the reason is shown against that service on **Claim Reports** and on **Online Claiming → Reports**. **Lodge only the rejected service again, as a new claim.** Never re-lodge services already paid: they would be refused as duplicates (code 9632).

SECTION 16

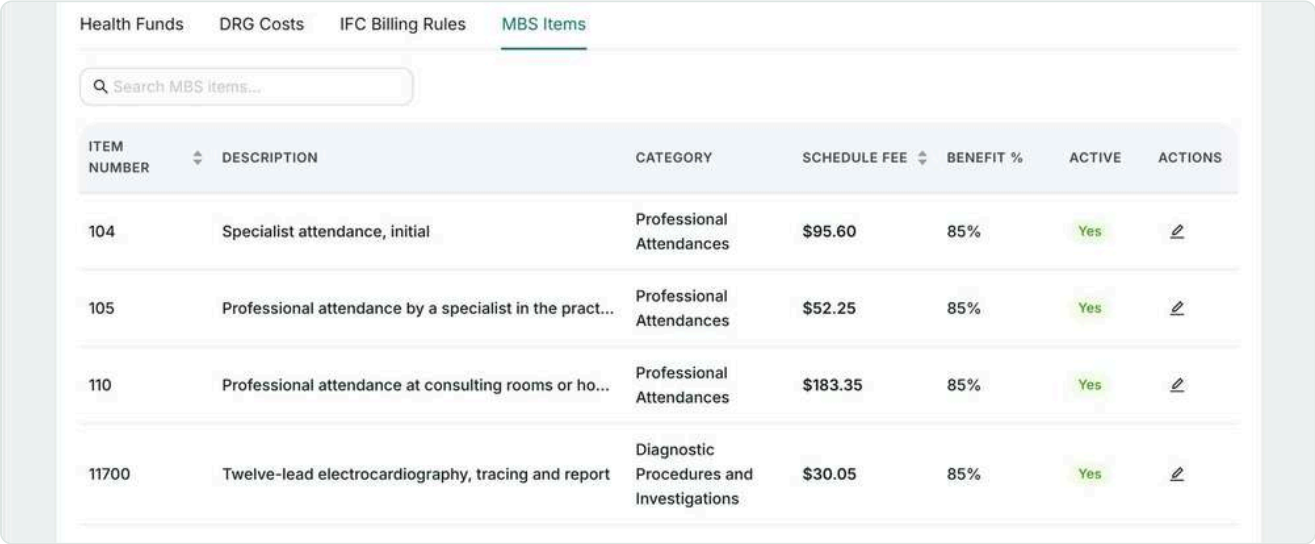
Keeping reference data up to date: MBS, reason codes, provider numbers, health funds

16.1 Updating MBS fees and item descriptions

HealthOS holds the Medicare Benefits Schedule: each item's number, description, schedule fee, 75% and 85% benefits, specialty and status. Claims are checked against it, including which items can be claimed together. The charge on a claim is always your own fee, entered on the claim.

HealthOS keeps the MBS up to date for you; your practice does not load or edit it. Fees and descriptions change when the Department of Health, Disability and Ageing publishes a new release (each 1 July, and amendments in between). HealthOS loads each release before it takes effect, from the MBS XML file on MBS Online (mbsonline.gov.au). A fee change becomes a new version of the item from its start date, so a claim for an earlier service keeps the earlier fee.

To see the current schedule, open **Care Admin → MBS Items** in the admin portal and use **Search MBS items...**. If an item looks wrong, or a release has not appeared by its start date, email support@healthos.net.au with the item number.



Care Admin → MBS Items in the admin portal: each Medicare Benefits Schedule item with its description, category, schedule fee and benefit.

How HealthOS loads a release (done by HealthOS platform administrators, because every organisation shares the schedule):

1. Download the MBS XML file from MBS Online as published (.xml, or gzipped .gz).

2. On **Care Admin → MBS Items**, choose **Import MBS Items** and drop the file in. HealthOS checks it first and writes nothing: it shows "n items ready to load" and lists anything it would leave out.
3. Choose **Load n items**. HealthOS reports how many items are new, corrected and unchanged.

16.2 Updating reason codes

Services Australia send each reason code **with its wording** on every check, claim and report. HealthOS shows both against the service they apply to: on the claim's answer, the Claim Reports card, the Reports tab and the Statement of Claim and Benefit. Because the wording arrives with each answer, it is always current, and **there is no reason-code table for you to update**. Section 17 lists the codes you will see most often.

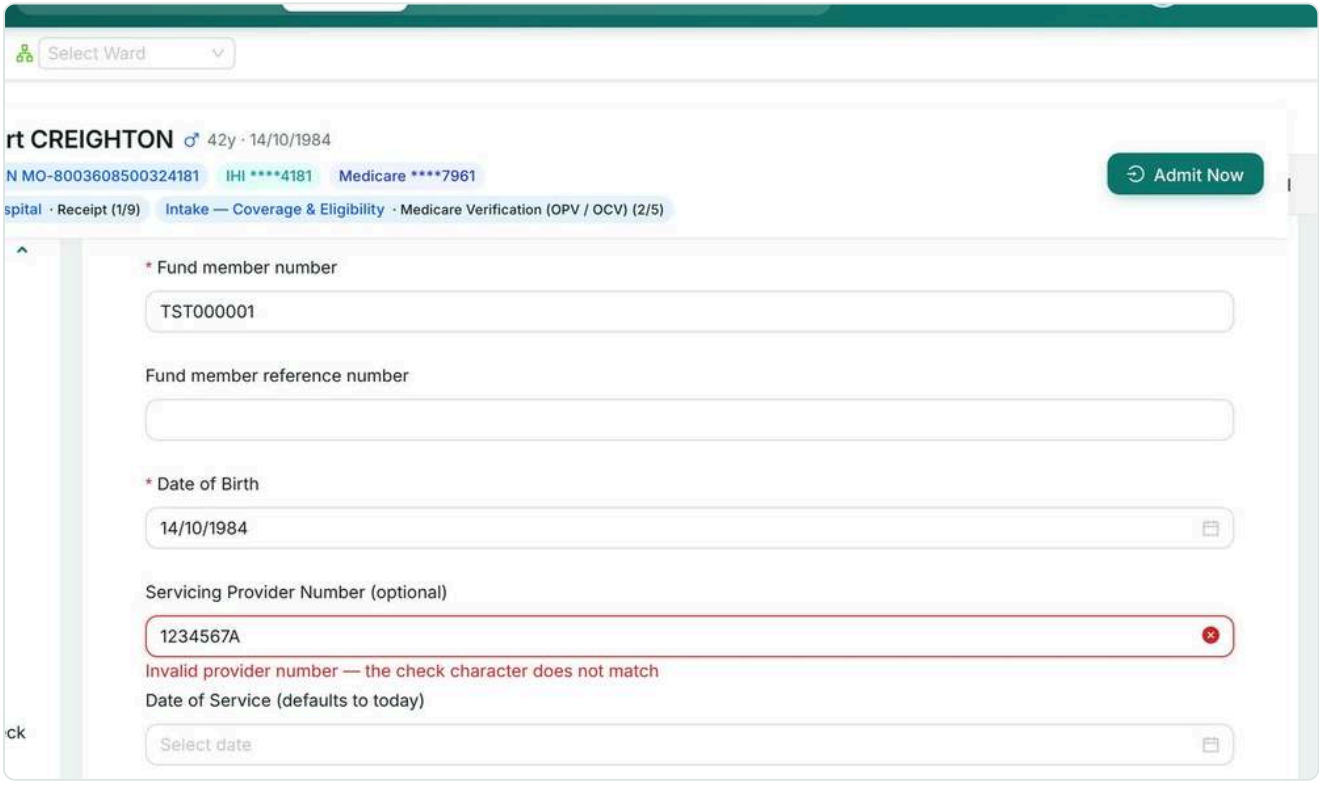
16.3 Updating provider numbers

A Medicare provider number is six digits, a location character and a check character (for example 2450841L). HealthOS checks each one as it is typed. A valid number shows a tick and "Provider number … is valid — check character matches"; a mistyped one is refused at the field ("Invalid provider number — the check character does not match") before anything is sent.

A claim can carry three provider numbers:

- **Servicing provider**: who gave the service. Needed on every claim.
- **Referring / requesting provider**: who referred or requested a specialist or diagnostic service.
- **Payee provider**: who is paid, when that is not the servicing provider.

Each practitioner's number is held on their record (**Medicare Provider Number**, entered when the practitioner is added). **When a practitioner's number changes** (for example they move to a new location), update it on their record. New drafts use the new number; drafts already created keep the old one, so correct them before lodging.



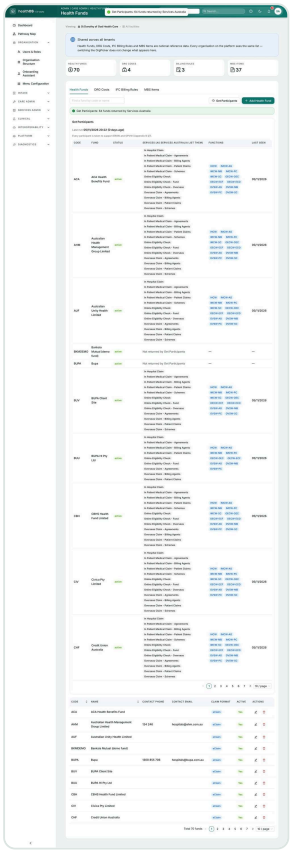
An invalid provider number refused at the field: "Invalid provider number — the check character does not match".

16.4 The health fund list

Services Australia maintain the list of health funds, and what each supports, for ECLIPSE claims and checks. To bring it up to date:

1. In the admin portal, open **Care Admin → Health Funds**.
2. Choose **Get Participants**. HealthOS fetches the current list from Services Australia and updates the table: "Get Participants: n funds returned by Services Australia".

Do this when a fund is refused as unknown, before billing a new fund, and from time to time. **Add Health Fund** and the edit action keep a fund's contact details.



Care Admin → Health Funds in the admin portal after Get Participants: "64 funds returned by Services Australia".

SECTION 17

Messages, errors and troubleshooting

17.1 Where problems show

- **Before anything is sent:** a field is checked as you type (Medicare card number, IRN, provider numbers, DVA file number, BSB) and the problem is named under it. Items that cannot be claimed together are named in a red box. A card that cannot be used yet says why (for example "No draft claim for this episode yet").
- **When Services Australia refuse:** a red box, such as **Lodgement failed** or **Verification failed**, then **"Services Australia: <code> — <text>"** in the agency's own words. Nothing was claimed.
- **When Services Australia accept with advice:** an amber or blue box with the code and wording; on a claim, each service shows its assessment and **Reason**.

- **Always:** the Transaction ID, and the full exchange on **Online Claiming → Transactions → Detail**.



A rejected lodgement as the operator sees it: "Lodgement failed — Services Australia: 7013 — Facility Id is not registered at the transmitting Location for IHCW DVA."

17.2 Messages and what to do

Search this table for the code or message you see.

CODE / MESSAGE	WHAT IT MEANS	WHAT TO DO
Vendor mode required	Claiming has not been switched on for your organisation	Ask your administrator (Appendix A)
No active episode — open this pathway from the patient chart's Care Admin section	The pathway was opened without the patient's episode	Open the patient's chart → Care Admin, with the episode selected
No draft claim for this episode yet	There is nothing to lodge	Create the draft on the Draft card first
Lodge claim unavailable on a bulk bill claim	The DB4 assignment is not recorded	Record it (section 7.2)
Lodge claim unavailable on an IMC patient claim	The patient's consent is not ticked	Show the consent and tick it (section 10)
Invalid provider number — the check character does not match	The provider number is mistyped	Re-enter it from the provider's details
Invalid Medicare card number	The card number is mistyped	Re-enter it from the card
These items cannot be claimed together	The items cannot go in one claim (for example specialist + pathology outside Group P9)	Lodge them as separate claims
The claim was adjusted	HealthOS reordered the items as the rules require (for example ECG items first)	Check it and carry on

CODE / MESSAGE	WHAT IT MEANS	WHAT TO DO
Nothing happens when you choose a document	The browser blocked the pop-up	Allow pop-ups for your HealthOS address
9633 — A new Medicare card has been issued	The card on record has been replaced	Confirm with the patient and choose **Update** (section 5.4)
9601 with MEDICARE_PENDABLE — needs referral to a Medicare Customer Services Officer	Medicare can't assess it automatically	Give the Lodgement Advice; **Resubmit to pend** (section 8.4)
9641 — A restrictive condition exists (MEDICARE_PENDABLE)	As above	As above
9645 — status other than Paid Same Day	The claim was pended, so it can't be deleted today	Medicare assesses it as usual. If it should not have been lodged, email support with the Transaction ID
9646 — The Claim could not be located by Medicare	The claim isn't assessed yet, or the transaction id is wrong	Check the claim is assessed and the transaction id
9202 — invalid value for a data item	A value isn't allowed (often a provider number)	Correct the field named and resubmit (section 15)
2030 — required item missing or contradictory	Two details that can't go together (for example a referral and a self-deemed code), or one missing	Keep the one that applies and resubmit
2032 — too many services in one medical event	One visit can hold at most 14 services	Add a second medical event
9632 — duplicate of a service already paid	The same item, patient and date has already been paid	If it really is a second service, record the time or duplicate-service override on the item; otherwise it was correctly refused
9011 — billing agent not authorised	The billing agent isn't registered against the provider	Email support with the Transaction ID; we check the provider's billing agent registration with Services Australia
7013 — Facility Id is not registered at the transmitting Location for IHCW DVA	The hospital's DVA Facility ID isn't linked to your location	Email support with the Transaction ID; we arrange for the facility to be linked to your location, then you resubmit
3004 — Services Australia system error	Services Australia couldn't process it	Try again later; if it keeps happening, email support with the Transaction ID
A message beginning DHSEIN	The message was refused before assessment	A HealthOS problem, not your data: email support with the Transaction ID
REPORT_NOT_READY	The report isn't produced yet	Wait; HealthOS asks again each morning
No report available	Processing finished with nothing to report	Nothing
PRODA device expires in N days (admin portal)	Claiming will stop when the PRODA device expires	Your administrator renews it (Appendix A.3)

CODE / MESSAGE	WHAT IT MEANS	WHAT TO DO
PRODA device has EXPIRED / authentication errors on every claim	Claiming has stopped	Your administrator re-activates the device (Appendix A.3)

17.3 Before you contact support

1. Note the **Transaction ID** and the exact message.
2. Open **Online Claiming → Transactions → Detail** for it, to see what was sent and what came back.
3. Email HealthOS support (section 1). We look at it with you, and raise it with Services Australia when it needs them.

APPENDIX A

Setting up claiming (for administrators)

An administrator of your organisation sets claiming up once, in the admin portal. Day-to-day users do not need this appendix. The full procedure is in the **HealthOS Installation and Authentication Guide**.

A.1 Configuring the software for Medicare Online, ECLIPSE and DVA claiming

When HealthOS sets your organisation up, it enters everything that belongs to the HealthOS software: your location's Minor ID, HealthOS's X-IBM-Client-Id, and the product name and version registered with Services Australia. **The only part your administrator completes is the PRODA device.**

What you need first

- Your organisation's PRODA **RA number**.
- A **B2B device** registered for HealthOS in PRODA, with its **device name** and one-time **device activation code** (A.2).
- Your location registered for Medicare Online on Services Australia's form HW027, using the Minor ID HealthOS gives you. HealthOS support helps you complete the form.

Run the Guided Setup

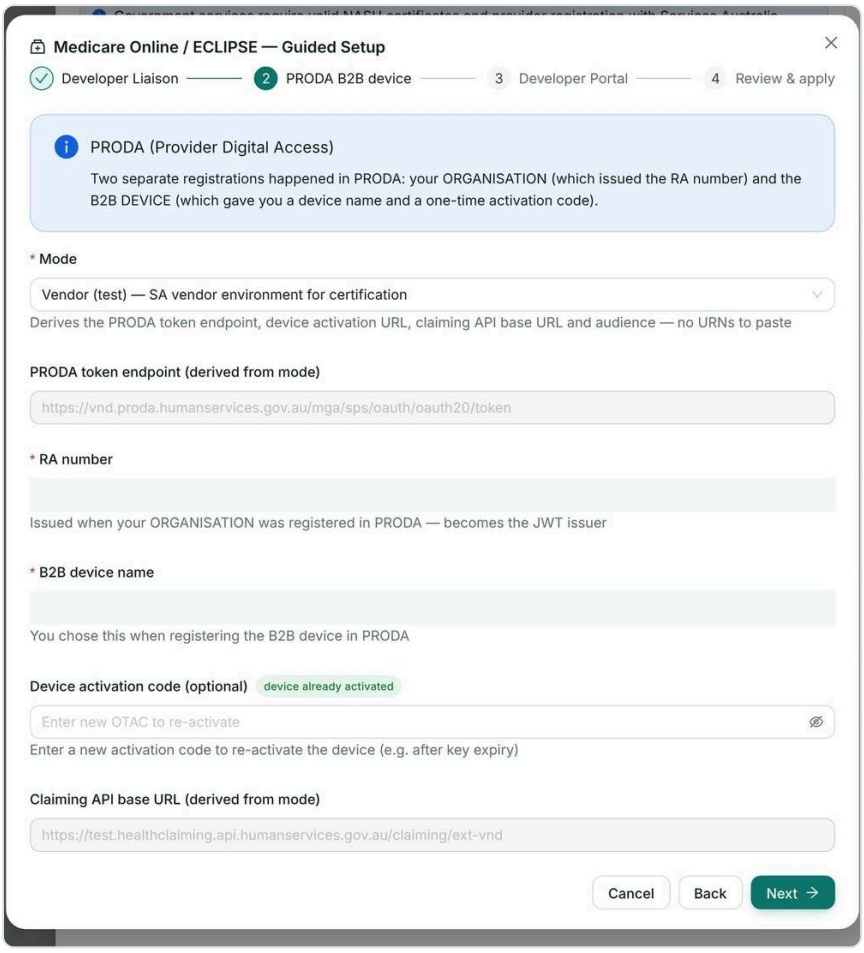
1. In the admin portal, open **Interoperability → Integration Topology** and select the **PRODA** or **Eclipse / Medicare Online** endpoint. The **Government gateways — Services Australia & Dept of Health** panel opens.
2. Choose **Medicare / ECLIPSE Guided Setup**.
3. **Developer Liaison** is already filled in by HealthOS. The **Developer ID** (your Minor ID) is read-only: only HealthOS can change it. Check the **Organisation name** is the one registered with Services Australia, and choose **Next**.
4. **PRODA B2B device**: leave the **Mode** on **Production** (Vendor and Mock are for HealthOS's own testing), and enter your **RA number**, the **B2B device name** and the **Device activation code**. The PRODA and claiming addresses are filled in from the mode.
5. **Developer Portal** is already filled in by HealthOS. Leave it as it is and choose **Next**.

6. **Review & apply**: check the values and choose **Apply**. HealthOS saves the settings, activates the device and tests the connection, showing a tick for each step.
7. When every step passes, it shows **"Medicare Online / ECLIPSE claiming is configured"**.

This one setup switches on all of Medicare Online, ECLIPSE (hospital and health fund claiming) and DVA claiming. Afterwards, refresh the health fund list (section 16.4). HealthOS does not connect to the Australian Immunisation Register (AIR), so there is no AIR setup.



The **Government gateways** panel in the admin portal, with the **Medicare / ECLIPSE Guided Setup** button at the top right. The **PRODA** row shows its status, last sync and device expiry with the days remaining; the **Eclipse / Medicare Online** row is below it.



The **PRODA B2B device** step of the Medicare / ECLIPSE Guided Setup, the one step you complete: the mode, your RA number and the B2B device name (both hidden here), and the device activation code. The PRODA token endpoint and the claiming address are filled in from the mode. Nothing is saved until you choose **Apply** on the last step. Shown here in HealthOS's test environment, so the mode reads Vendor (test); yours reads Production.

A.2 PRODA: how it works with HealthOS, and registering the B2B device

Services Australia check every claim through **PRODA** (Provider Digital Access). HealthOS uses a PRODA **B2B device**: your organisation registers a device for HealthOS once, HealthOS activates it with a one-time code, and after that HealthOS signs every request with the device's key. **Staff never sign in to PRODA to claim.**

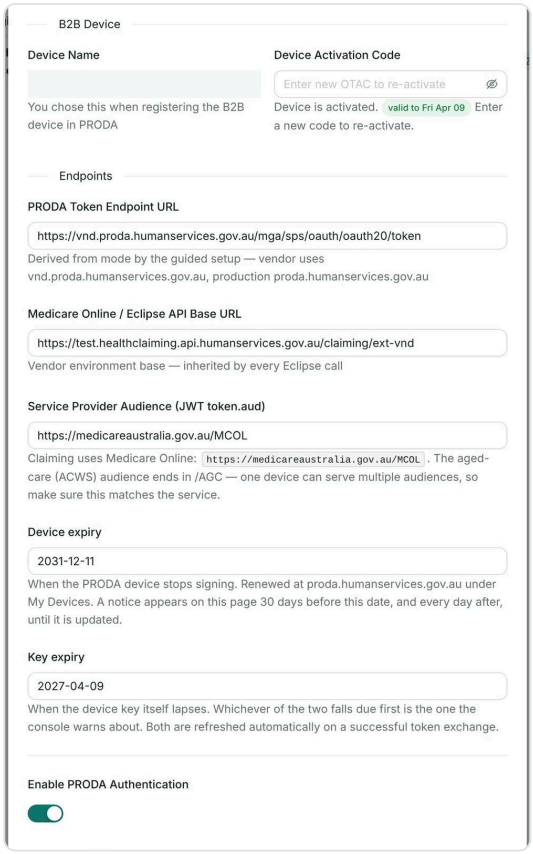
For more about PRODA, see Services Australia's page **PRODA (Provider Digital Access) - Services Australia**: https://www.servicesaustralia.gov.au/proda-provider-digital-access

Set up the one-time activation code and register the device (a PRODA member of your organisation who can manage B2B devices):

1. Sign in to PRODA (https://proda.humanservices.gov.au), select **Organisations** and choose your organisation.
2. In the **B2B Devices** drop-down, choose **Register New B2B Device**.
3. Enter a device name (for example HealthOS-B2B-Device) and a description, and choose **Register Device**. Write the name down exactly.
4. PRODA shows the **device activation code**. It works once and expires after **1 day** in production, so choose **Copy to Clipboard** and go straight on.
5. In the HealthOS Guided Setup's **PRODA B2B device** step (A.1), enter the RA number, the device name and the activation code, and choose **Apply** on the last step.

6. The **Activate PRODA B2B device** step shows a tick, and the PRODA row in the Government gateways panel shows **Connected** with the device's expiry date.

If the code had expired or was mistyped, the step shows **Activation failed**. Generate a new code in PRODA and apply again.



Part of **PRODA B2B Authentication Configuration** in the admin portal: the B2B device (its name hidden here) and whether it is activated, the addresses the mode sets, the service provider audience, **Device expiry**, **Key expiry** and **Enable PRODA Authentication**. The **Re-activate Device** and **Test Authentication** buttons are at the foot of the form.

A.3 Keeping the PRODA device current

- **The device key** renews itself: HealthOS replaces it automatically in the week before it expires. Nobody needs to act.
- **The device** must be renewed in PRODA by your organisation before its expiry date. Then open the PRODA settings in HealthOS (the PRODA row's edit action) and save the new **Device expiry**.

From **30 days** before either date, the Government gateways panel shows "PRODA device expires in N days — renew the Device in PRODA". It turns red in the last 7 days, and cannot be dismissed. If the date passes ("PRODA device has EXPIRED"), claiming stops: generate a new activation code in PRODA and choose **Re-activate Device** in the PRODA settings.

APPENDIX B

Glossary

TERM	MEANING
Assessed	Medicare has worked out the benefit for a claim
B2B device	The PRODA record that lets HealthOS prove to Services Australia that it is acting for your organisation
Bulk bill	The patient pays nothing and assigns their Medicare benefit to the provider
DB4	The bulk bill assignment of benefit form the patient signs
ECLIPSE	Services Australia's channel for hospital, specialist and health fund claims
Eligibility check (OEC)	A quote from Medicare and/or a health fund before a planned admission. It claims nothing
ERA (remittance advice)	A health fund's statement of what it paid, against which claims
IRN	Individual Reference Number: the patient's position on the Medicare card
Lodgement Advice	The document given when a patient claim is received but not yet assessed
Medical event	One visit's services within a claim
Minor ID	Your claiming location's identifier with Services Australia; every Transaction ID starts with it
Pended / pendable	A patient claim Medicare cannot assess automatically, queued for a Medicare officer
PRODA	Provider Digital Access: Services Australia's sign-in and authentication service
RA number	Your organisation's PRODA registration number
Statement of Claim and Benefit	The document given when a patient claim is assessed, showing the benefit
Transaction ID	The reference HealthOS and Services Australia both use for one check, claim or report

APPENDIX C

For Services Australia: Developer's Guide section 6.1

This appendix is for the Services Australia assessor. It shows where this manual answers each item of the user manual checklist in section 6.1 of the Medicare Online and ECLIPSE Web Services Developer's Guide V2.2.1 (pages 27–28). Page numbers refer to the PDF edition. The software is registered as **HealthOS_Prod_MCOL_v1.0**.

6.1 ITEM	REQUIREMENT (ABRIDGED)	ANSWERED IN	PAGE
1	Contact details for customers needing assistance and support	Section 1	4
2	How to install and/or access the software	Section 2, and the Installation and Authentication Guide	5
3	Troubleshooting: possible errors and how to fix them	Section 17	70
4	Locate content by searching words or phrases	"How to find what you need"	2
5a	Brief description of the Statement of Claim and Benefit	Section 13.1	57
5b	Brief description of the Lodgement Advice	Section 13.2	58
6	Step-by-step instructions with screenshots of all claiming functions	Sections 5 to 15	14
7a	Configure the software to enable all Medicare Online (incl. DVA and AIR) and ECLIPSE claiming functions	Appendix A.1 (AIR is not supported, stated there and in section 3)	73
7b	How PRODA interacts with the software, incl. the one-time code and registering the B2B device	Appendix A.2 and A.3	75
7c	Link to the agency's PRODA page	Appendix A.2	75
7d	How to update Medicare Benefits Schedule fee changes	Section 16.1	68
7e	How to update MBS item descriptions, reason codes and provider numbers	Sections 16.1, 16.2 and 16.3	68
7f	How to resubmit rejected services	Section 15	66
7g	Reporting, reconciliation processes and report retrieval	Section 14	61

C.1 Web services and where each is used

WEB SERVICE	USED FOR	SECTION
OPVW — Online Patient Verification (PVM, PVF, OPV)	Checking a Medicare card and/or health fund membership	5.1, 5.2
OCVW — Online Concession Verification	Checking a concession card	5.3
OVVW — Online Veteran Verification	Checking a DVA file number and card	5.3
OECW — Online Eligibility Check (ECM, ECF, OEC, ECO)	Quoting a planned admission	6
BBSW — Bulk Bill Store and Forward	Bulk bill claims, batches and the DB4	7
PCIW — Patient Claim Interactive	Patient claims, pend and resubmit, store and lodge later	8
SDDW — Same Day Delete	Withdrawing a patient claim on the day	8.6
DVAW / VAAW — DVA medical / allied health and community nursing	DVA claims	9
IMCW — In-patient Medical Claims	In-patient medical claims through ECLIPSE	10

WEB SERVICE	USED FOR	SECTION
IHCW — In-Hospital Claims (public, private, private-DVA)	In-hospital claims through ECLIPSE	11
OVSW — Overseas claims	Overseas visitor claims	12
BPRW / BPYW, DVRW / DVYW — processing and payment reports	Bulk bill and DVA outcomes and payments	14
BIRW — Bulk Bill Integrated report	Integrated bulk bill report by transaction id	14.3
STSW / RTVW — status and retrieve reports	Report readiness; IMC, IHC and OVS claim reports	14.3
ERAW — ECLIPSE Remittance Advice	Health fund payments	14.4
GPRW — Get Participants	The health fund list	16.4

healthOS

Help with claiming

Email **support@healthos.net.au** with your organisation, what you were doing and the Transaction ID. We handle anything that needs Services Australia for you.

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