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DEPARTMENT OF EMPLOYMENT AND LABOUR

NO. 7253 **20 March 2026**

AMBULANCE GAZETTE 2026

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REPUBLIC OF SOUTH AFRICA

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Compensation Fund

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COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (ACT No. 130 OF 1993), AS AMENDED

ANNUAL INCREASE IN MEDICAL TARIFFS FOR MEDICAL SERVICES PROVIDERS.

1. I, Nomakhosazana Meth, Minister of Employment and Labour, hereby give notice that, after consultation with the Compensation Board and acting under powers vested in me by section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.130 of 1993), prescribe the scale of "Fees for Medical Aid" payable under section 76, inclusive of the General Rule applicable thereto, appearing in the Schedule, with effect from 1 April 2026.

2. Medical Tariffs will increase by 6% for the financial year 2026/27.

3. The fees appearing in the Schedule are applicable in respect of services rendered from 1 April 2026 and exclude 15% VAT

Ms. N Meth, MP

MINISTER OF EMPLOYMENT AND LABOUR

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GENERAL INFORMATION

1. MEDICAL SERVICE PROVIDERS REGISTRATION REQUIREMENTS WITH THE COMPENSATION FUND

- The Compensation Fund requires that any Medical Service Provider, treating patients in terms of the COID Act, must be registered with The Compensation Fund through the submission of copies of the following documents to the nearest labour centre:
  a. A duly completed original Banking Details form (WAC 33) (download in PDF from www.labour.gov.za)
  b. The latest copy of valid BHF certificate
  c. Recent bank statement with bank stamp or bank letter
  d. Proof of practice address not older than 3 months.
  e. SARS VAT registration number/ certificate if VAT registered. (If this is not provided the medical practitioner will be registered as a non-VAT vendor)
  f. A power of attorney is required if the MSP has appointed a third party to do their administration of their COID claims.

2. REGISTERING WITH THE COMPENSATION FUND AS AN ONLINE SYSTEM USER FOR MEDICAL SERVICE PROVIDERS

- To register as an online user of the claims processing system, COMPEASY, the following steps must be followed:

  a. Register as an online user with the Department of Employment and Labour website (www.labour.gov.za)
  b. Register on the CompEasy application having the following documents to upload
     - A certified copy of identity document (not older than a month from the date of application)
     - Latest copy of valid BHF certificate
     - Proof of address not older than 3 months

- In the case where a medical service provider has appointed a third party to administer their COID claims with the Fund, the following ADDITIONAL documents must be uploaded:

  - An appointment letter for proxy (the template is available online)
  - The proxy's certified identity document (not older than a month from the date of application)
  - There are instructions online to guide a user on successfully registering (www.compeasy.gov.za)

3. THIRD PARTIES TRANSACTING ON BEHALF OF MEDICAL SERVICE PROVIDERS

- Third Parties that provide administration services on behalf of medical service providers must take note of the following:
  - **a.** They must be able to obtain and make available copies of the original claim documents and medical invoices from medical service providers.
  - **b.** They must keep such records in their original state as received from the medical service provider and must furnish the Compensation Commissioner with such documents on request for the purposes of auditing.
- The Fund will not provide or disclose any information related to a medical service provider, represented by a third party, where such information relates to a period prior to them being contracting to a third party.

4. THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

Medical Service Providers are encouraged to take note of the following guidance when treating patients in terms of the Compensation for Occupational Injuries and Diseases Act of 1993 (COID Act):

a. Employees as defined in the COID Act of 1993, are generally free to choose their preferred Medical Service Provider, provided that such choice is exercised reasonably and without prejudice to the employee or the Compensation Fund.
- An exception applies where an employer, with the approval of the Compensation Fund, provides comprehensive medical aid facilities to its employees, e.g. Hospital, nursing and other medical services, as contemplated in Section 78 of the COID Act, in such cases, treatment arrangements may differ.

b. In terms of Section 42 of the COID Act, the Compensation Fund may refer an injured employee to a specialist medical service provider designated by the Director General for a medical examination and report. Medical Service providers should cooperate with such referrals where they occur.

c. Medical Service Providers are reminded that in accordance with section 76(3)(b) of the COID Act, medical expenses may not be recovered from the employee. Providers should therefore avoid billing employees directly for services that fall within accepted COID claims.

d. Where a change of Medical Service Providers occurs, the first treating doctor is generally regarded as the principal treating doctor, unless the case is transferred to a specialist.

e. To promote continuity of care and avoid disputes, Medical Service Providers are encouraged not to treat an employee who is already under the care of another practitioner without first consulting or informing the principal treating doctor.

f. Any changes of medical service providers should be supported by sufficient reasons, and such reasons should be communicated to the Compensation Fund to ensure clarity and proper case management.

g. In line to section 5 of the National Health Act no 61 of 2003, a health care provider may not refuse a person emergency medical treatment. In emergency situations, Medical Service Providers are not required to obtain prior authorisation from the Compensation Fund before rendering such treatment even if the claim has not yet been registered or accepted.

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h. Employees who seek medical treatment do so at their own risk where they have not informed their employer and/or the Compensation Fund of possible grounds for a COID claim. Medical Service Providers should be aware that, under such circumstances, The Compensation Fund may not accept responsibility for the settlements of the medical expenses incurred.
i. Where a claim is repudiated by the Compensation Fund, the employee is regarded in the same position as any other member of the public in respect of payment for medical services rendered.

5. OVERVIEW OF THE COID CLAIMS PROCESS

- All claims lodged in the prescribed manner with the Compensation Fund are subjected to the following process:

a. New claims are registered by the Employers with the Compensation Fund in the prescribed manner. Details and progress of the claim can be viewed on the online processing system for registered users of the system.
b. Proof of identity is required through the submission of a copy of an Identity document/card, will be required for a claim to be registered with the Compensation Fund. In the case of foreign nationals, the proof of identity (passport) must be certified.
c. All supporting documentation submitted to the Compensation Fund must reflect the identity and claim numbers of the employee.
d. Once an incident is reported to the Fund a claims number will be allocated to acknowledge receipt, but this does not imply acceptance of liability for the claim.
e. On acceptance of liability for claims in terms of the COID Act, all reasonable medical expenses, arising from the related medical condition shall be paid to medical service providers, and in accordance to approved tariffs, billing rules and procedures as published in the medical tariff gazettes of the Compensation Fund.
f. If a claim is repudiated in terms of the COID Act, medical expenses, will not be payable. The employer and the employee will be informed of this decision, and the injured employee will be liable for payment of medical costs incurred.
g. In the event of insufficient claim information being made available to the Compensation Fund, the claim will be rejected until the outstanding information is submitted and liability can be determined.
h. Manner of payment of medical benefits for Compensation Fund claims, where liability has been accepted (adjudicated) on or after 1 April 2025.
   - All medical invoices for accepted claims must be submitted, in the prescribed manner within 36 months of the date of acceptance of liability.
   - And or within 36 months from the date of service, which ever may apply.
   - Medical invoices received after said time frame will be considered as late submission of invoices and may be rejected.
i. All service providers should be registered on the Compensation Fund claims processing system to capture medical invoices and medical reports for medical services rendered.
j. Submission of medical reports and invoices is permitted solely for claims where liability has been accepted by the Compensation Fund and where payment of reasonable medical expenses is authorised.

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6. BILLING REQUIREMENTS FOR MEDICAL SERVICES PROVIDED TO INJURED OR DISEASED EMPLOYEES

Submission of Medical Reports

- In terms of section 74(1)– (5) of the Compensation for Occupational Injuries and Diseases Act, 1993 (COID Act), every Medical Service Provider shall submit the prescribed medical reports when claiming from the Compensation Fund.
- The First Medical Report (W.CL 4), completed after the initial consultation, shall:
  - Confirm the clinical description of the injury or disease.
  - Detail all procedures performed; and
  - Record all referrals to other medical service providers, where applicable.
- All follow up consultations shall be recorded on a Progress Medical Report (W.CL 5). Any procedure or operation performed during the reporting period shall be clearly detailed, including all referrals, where applicable.
- A Progress Medical Report shall cover a maximum period of thirty (30) days, except where a procedure has been performed during that period, in which case an additional operation report shall be submitted.
- Where multiple procedures are performed on the same date of service, only one medical report shall be submitted in respect of that service date.
- Upon stabilisation of the injury or disease, a Final Medical Report (W.CL 5F) shall be completed and submitted
- Medical Service Providers shall attach a medical report or other appropriate medical documentation to every claim submitted to the Compensation Fund.
- Medical Service Providers shall retain copies of all submitted medical reports and shall make such records available to the Compensation Commissioner upon request.
- With effect from 1 April 2025, **ALL** medical practitioners shall submit relevant patient records together with medical invoices for services rendered. **(This includes hospitals, anaesthetists and any other practitioners that have not previously been required to do so)**

Submission of Medical Invoices

- Medical invoices shall be submitted only in respect of claims for which liability has been formally accepted by the Compensation Fund and where payment of reasonable medical expenses has been authorised.
- The submission of medical invoices without the required accompanying medical documentation shall be strictly prohibited and shall result in rejection of the invoice.
- Duplicate invoices shall not be submitted under any circumstances.
- Running accounts or statements shall not be accepted and shall be rejected at system level.

Minimum Information Requirements for Medical Invoices

Every medical invoice submitted to the Compensation Fund shall, at a minimum, include the following information:

- The allocated Compensation Fund claim number.
- The full name, surname and identity number of the employee.
- The name and Compensation Fund registration number of the employer, as reflected on the Employer's Report of Accident (W.CL 2);

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- The date of accident.
- The date(s) of service rendered.
- The Medical Service Provider's BHF practice number.
- The VAT registration number of the Medical Service Provider, where applicable.
- The applicable tariff code(s) as published in the approved tariff gazettes.
- The amount claimed per tariff code, quantity, total amount claimed including the correct sequencing of modifiers where applicable.
- A unique invoice number.

(Medical invoices that do not comply with the prescribed minimum information requirements shall be rejected and shall not be processed for payment).

VAT and Tariff Application

- Published tariff amounts shall be assessed exclusive of VAT.
- VAT shall be applied only where the Medical Service Provider is a registered VAT vendor and has supplied a valid VAT registration number on the invoice.
- Where no VAT registration number is provided, the Medical Service Provider shall be regarded as a non-VAT vendor and VAT shall not be applied.
- Notwithstanding the above, the following tariffs shall be processed as VAT inclusive:
    - Per diem tariffs applicable to private hospitals; and
    - VAT exempt tariff codes applicable to private ambulance services.

Pharmaceuticals and Referrals

- All pharmaceutical claims shall be submitted in accordance with the NAPPI file and shall be accompanied by the original prescription(s).
- Where a referral is required, the referring practitioner's referral letter shall accompany the medical invoice.

Enforcement and Non-Compliance

- The Compensation Fund shall withhold payment of any medical invoice that fails to comply with the billing and submission requirements prescribed in this document and as published in the Government Gazette.
- Noncompliance with these billing requirements shall result in rejection of claims and may result in further remedial or enforcement action by the Compensation Fund.

7. INVOICING REQUIREMENT ON MEDICAL CLAIMS FOR ICD-10 CODES

As part of improved delivery service and efficiency, The Compensation Fund has implemented ICD-10 rules that must be adhered to when submitting medical invoices. This will be rolled out in a phased approach. The first phase currently active on the system is outlined below:

ICD-10 Validations

ICD-10 validations will apply in accordance with the national ICD-10 Phase 3 and Phase 4.1 requirements and include the following:

- Valid ICD-10 codes as per the SA ICD-10 Master Industry Table
- Maximum level of specificity: ICD-10 codes must be valid at the correct 3-, 4-, or 5-character level
- Valid ICD-10 primary codes (codes not valid as primary will be rejected)
- Compliance with the dagger and asterisk rule

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- Compliance with sequelae coding rules
- Age edits for ICD-10 codes with age requirements
- Gender edits
- All injury and poisoning codes must be accompanied by external cause codes

Please ensure that you are familiar with the above requirements to avoid unnecessary claim rejections. The date and requirements for the next phase will be communicated in due course.

8. REQUIREMENTS FOR SWITCHING MEDICAL INVOICES WITH THE COMPENSATION FUND

A switching provider must comply with the **following** requirements:

1. Register with the Compensation Fund as an employer where applicable in terms of the COID Act 1993
2. Host a secure FTP (or SFTP) server to ensure encrypted connectivity with the Fund. This requires that they ensure the following:
    a. Disable Standard FTP because is now obsolete. ...and use latest version and reinforce FTPS protocols and TLS protocols.
    b. Use Strong Encryption and Hashing.
    c. Place Behind a Gateway.
    d. Implement IP Blacklists and Whitelists.
    e. Harden Your FTPS Server.
    f. Utilize Good Account Management.
    g. Use Strong Passwords.
    h. Implement File and Folder Security.
    i. Secure your administrator and require staff to use multifactor authentication.
3. Submit and complete successful test file after registration before switching invoices.
4. Verify medical service provider's registration with the Board of Healthcare Funders of South Africa.
5. Submit medical invoices with gazetted COIDA tariffs that are published annually.
6. Comply with medical billing requirements of the Compensation Fund.
7. Single batch submitted must have a maximum of 150 medical invoices.
8. Eliminate duplicate invoices before switching to the Fund.
9. File name must include a sequential batch number in the file naming convention.
10. File names to include sequential number to determine order of processing.
11. Only pharmacies should claim from the NAPPI file.

PLEASE NOTE: Failure to comply with the above requirements will result in deregistration / penalty imposed on the switching house.

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COMPEASY ELECTRONIC INVOICING FILE LAYOUT

*** Mandatory fields**

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

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FIELD	DESCRIPTION	Max Length	DATA TYPE	MANDATORY
35	Treating Doctor BHF practice number	9	Alpha	
36	Dosage duration (for medicine)	4	Alpha	
37	Tooth numbers		Alpha	*
38	Gender (M, F)	1	Alpha	
39	HPCSA number	15	Alpha	
40	Diagnostic code type	1	Alpha	
41	Tariff code type	1	Alpha	
42	CPT code / CDT code	8	Numeric	
43	Free Text	250	Alpha	
44	Place of service	2	Numeric	*
45	Batch number	10	Numeric	
46	Switch Medical scheme identifier	5	Alpha	
47	Referring Doctor's HPCSA number	15	Alpha	*
48	Tracking number	15	Alpha	
49	Optometry: Reading additions	12	Alpha	
50	Optometry: Lens	34	Alpha	
51	Optometry: Density of tint	6	Alpha	
52	Discipline code	7	Numeric	
53	Employer name	40	Alpha	*
54	Employee number	15	Alpha	*
55	Date of Injury (CCYYMMDD)	8	Date	*
56	IOD reference number	15	Alpha	
57	Single Exit Price (Inclusive of VAT)	15	Numeric	
58	Dispensing Fee	15	Numeric	
59	Service Time	4	Numeric	
60				
61				
62				
63				
64	Treatment Date from (CCYYMMDD)	8	Date	*
65	Treatment Time (HHMM)	4	Numeric	*
66	Treatment Date to (CCYYMMDD)	8	Date	*
67	Treatment Time (HHMM)	4	Numeric	*
68	Surgeon BHF Practice Number	15	Alpha	
69	Anaesthetist BHF Practice Number	15	Alpha	
70	Assistant BHF Practice Number	15	Alpha	
71	Hospital Tariff Type	1	Alpha	
72	Per diem (Y/N)	1	Alpha	
73	Length of stay	5	Numeric	*
74	Free text diagnosis	30	Alpha	
TRAILER				
1	Trailer Identifier = Z	1	Alpha	*
2	Total number of transactions in batch	10	Numeric	*
3	Total amount of detail transactions	15	Decimal	*

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MSPs PAID BY THE COMPENSATION FUND

Discipline Code:	Discipline Description:
004	Chiropractors
009	Ambulance Services - Advanced
010	Anesthesiology
011	Ambulance Services - Intermediate
012	Dermatology
013	Ambulance Services - Basic
014	General Medical Practice
015	General Medical Practice
016	Obstetrics and Gynecology (Occupational related cases)
017	Pulmonology
018	Specialist Medicine
019	Gastroenterology
020	Neurology
021	Cardiology (Occupational Related Cases)
022	Psychiatry
023	Medical Oncology
024	Neurosurgery
025	Nuclear Medicine
026	Ophthalmology
028	Orthopaedic
030	Otorhinolaryngology
034	Physical Medicine
035	Emergency Medicine Independent Practice Speciality
036	Plastic and Reconstructive Surgery
038	Diagnostic Radiology
039	Radiography
040	Radiation Oncology
042	Surgery Specialist
044	Cardio Thoracic Surgery
046	Urology
049	Sub-Acute Facilities
052	Pathology
054	General Dental Practice
055	Mental Health Institutions
056	Provincial Hospitals
057	Private Hospitals
058	Private Hospitals
059	Private Rehab Hospital (Acute)
060	Pharmacy
062	Maxillo-facial and Oral Surgery
066	Occupational Therapy
070	Optometry
072	Physiotherapy
075	Clinical technology (Renal Dialysis and Perfusionists)
076	Unattached operating theatres / Day clinics
077	Approved U O T U / Day clinics

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078	Blood transfusion services
079	Hospices/Frail Care
082	Speech therapy and Audiology
083	Hearing Aid Acoustician
084	Dietetics
086	Psychology
087	Orthotics & Prosthetics
088	Registered nurses (Wound Care and Nephrology only)
089	Social worker
090	Clinical services: (Wheelchairs and Gases only)
094	Prosthodontic

POPI ACT COMPLIANCE

In terms of Protection of Personal Information Act, 2013 (POPI Act), the Compensation Fund wants to assure Employees and the Medical Service Providers that all personal information collected is treated as private and confidential. The Compensation Fund has put in place the necessary safeguards and controls to maintain confidentiality, prevent loss, unauthorised access and damage to information by unauthorised parties.

AMBULANCE GAZETTE 2026

AMBULANCE TARIFF OF FEES AS FROM 1 APRIL 2026 (PRACTICE TYPE 009, 011, 013)	
General Rules	
Rule	**Rule Description**
001	Road ambulances: Long distance claims (items 111, 129 and 141) will be rejected **unless the distance travelled with the patient** is reflected. Long distance charges may not include item codes 100,102,103,125,127,131 or 133. Long distance claims (items 112, 130 and 142) to be rejected unless the distance is reflected.
002	No after hours fees may be charged.
003	Road ambulances: Item code 151 (resuscitation) may only be charged for services provided by a second vehicle (either ambulance or response vehicle) and shall be accompanied by a motivation. Disposables and drugs used are included unless specified as additional cost items. (Refer to Section 7: Nationally approved medication)
004	A **BLS** (Basic Life Support) practice (Pr. No. starting with 13) may **not** charge for **ILS** (Intermediate Life Support) or **ALS** (Advanced Life Support); an **ILS** practice (Pr. No. starting with 11) may **not** charge for **ALS.** An **ALS** practice (Pr. No. starting with 09) **may charge for all codes.**
005	A second patient is transferred at 50% reduction of the basic call cost. Rule 005 MUST be quoted if a second patient is transported in any vehicle or aircraft in addition to another patient. Refer to Aeromedical transfers section 5.
006	**Guidelines for information required on each ambulance invoice:**
	Road and air ambulance invoices . Name and ID number of the employee. · Diagnosis of the employee's condition. . The date on which the service was rendered. · Summary of all equipment used if not covered in the basic tariff. . Summary of medical procedures undertaken on patient and vital signs of patient. · Name, practice number and HPCSA registration number of the medical doctor. · Response vehicle: details of the vehicle driver and the intervention undertaken on patient. · Place and time of departure and arrival at the destination as well as the exact distance travelled (Air ambulance: exact time travelled from base to scene, scene to hospital and back to base. Road Ambulance: exact time travelled from base to scene, scene to hospital). · Details of the trip sheet should be captured in a medical report provided for on the COID system. PLEASE NOTE: VAT cannot be added on the following codes 102,103,111,125,127,129,131,133 and 141.
	Definitions of Ambulance Patient Transfer
	Basic Life Support - A callout where the patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Basic Ambulance Assistant whilst the patient is in transit. **Intermediate Life Support** - A callout where the patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Ambulance Emergency Assistant (AEA), e.g. initiating and/or maintaining IV therapy, nebulisation etc. whilst the patient is in transit. **Advanced Life Support** - A callout where the patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered paramedic (Critical Care Assistant (CCA) and NDIP) whilst the patient is in transit. **NOTES:** If a hospital or doctor requires a paramedic to accompany the patient on a transfer in the event of the patient needing ALS / ILS intervention, the doctor requesting the paramedic must write a detailed motivational letter in order for ALS / ILS fees to be charged for the transfer of the patient. · In order to bill an Advanced Life Support call, a registered Advanced Life Support provider must have examined, treated and monitored the patient whilst in transit to the hospital. · In order to bill an Intermediate Life Support call, a registered Intermediate Life Support provider must have examined, treated and monitored the patient whilst in transit to the hospital. · When an ALS provider is in attendance at a callout but does not do any interventions on the patient at an ALS level, the billing should be based on a lesser level, dependent on the care given to the patient.(E.g. if a paramedic sites an IV line or nebulises the patient with a B-agonist which falls within the scope of practice of an AEA, the call is to be billed as an ILS call and not an ALS call.) · Where the management undertaken by a paramedic or AEA falls within the scope of practice of a BAA the call must be billed at a BLS level.

	Please Note · The amounts reflected in the COIDA Tariff Schedule for each level of care are inclusive of any disposables (except for pacing pads, Heimlich valves, high capacity giving sets, dial-a-flow and intra-osseous needles) and drugs used in the management of the patient, as per the attached nationally approved medication protocols. · Haemaccel and colloid solution may be charged for separately. · An ambulance is regarded by the Compensation Fund as an emergency vehicle that administers emergency care and transport to those employees with acute injuries and only such emergency care and transport will be paid for by the Compensation Fund. A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment. · Claims for transfers between hospitals or other service providers must be accompanied by a motivation from the attending doctor who requested such transport. The motivation should clearly state the medical reasons for the transfer. Motivation must also be provided if ILS or ALS is needed and it should be indicated what specific medical assistance is required on route. This is also applicable for air ambulances. · Transportation of an employee from his home to a service provider, this includes outpatients between two service providers, if not in an emergency situation, it is not payable. In emergency cases such transport should be motivated for and the attending doctor should indicate what specific medical assistance is required on route. . Claims for the transport of a patient discharged home will only be accepted if accompanied by a written motivation from the attending doctor who requested such transport, clearly stating the medical reasons why an ambulance is required for such transport. It should be indicated what specific medical assistance the patient requires on route. If such a request is approved only BLS fees will be payable. Transport of a patient for any other reason than a MEDICAL reason, (e.g. closer to home, do not have own transport) will not be entertained.			
	DEFINITION: RESPONSE VEHICLES			
1.	**Response vehicles only - Advance Life Support (ALS)**			
	A clear distinction must be drawn between an acute primary response and a booked call.			
	An Acute Primary Response is defined as a response to a call that is received for medical assistance to an employee injured at work or in a public area e.g. motor vehicle accident. If a response vehicle is dispatched to the scene of the emergency and the patient is in need of advanced life support and such support is rendered by the ALS Personnel e.g. CCA or National Diploma, the response vehicle service provider shall be entitled to bill item 131 for such service. However, the same or any other ambulance service provider which is then transporting the patient shall not be able to levy a bill as the cost of transportation is included in the ALS fee under item 131. Furthermore, the ALS response vehicle personnel must accompany the patient to the hospital to entitle the original response vehicle service provider to bill for the ALS services rendered.			
2.	In the event of a response vehicle service provider rendering ALS and not having its own ambulance available in which to transport the patient to a medical facility, and makes use of another ambulance service provider, only the bill for the response vehicle service may be levied as the ALS bill under item 131. Since the ALS tariff already includes transportation, the response vehicle service provider is responsible for the bill for the other ambulance service provider, which will be levied at a BLS rate. This ensures that there is only one bill levied per patient.			
3.	Should a response vehicle go to a scene and not render any ALS treatment then a bill may not be levied for the said response vehicle.			
4.	Notwithstanding 3, item 151 applies to all ALS resuscitation as per the notes in this schedule.			
4.1	**Response vehicle only - Intermediate Life Support (ILS)**			
	A clear distinction must be drawn between the acute primary response and a booked call.			
	An Acute Primary Response is defined as a response to a call that is received for medical assistance to an employee injured at work or in a public area e.g. motor vehicle accident. If an ILS response vehicle is dispatched to the scene of the emergency and the patient is in need of intermediate life support and such support is rendered by the ILS Personnel e.g. AEA, the response vehicle service provider shall be entitled to bill item 125 for such service. However, the same or any other ambulance service provider which is then transporting the patient shall not be able to levy a bill as the cost of transportation is included in the ILS fee under item 125. Furthermore, the ILS response vehicle personnel must accompany the patient to the hospital to entitle the original response vehicle service provider to bill for the ILS services rendered.			

Code	Code Description	Practice 13	Practice 11	Practice 9
4.2	In the event of a response vehicle service provider rendering ILS and not having its own ambulance available in which to transport the patient to a medical facility, and makes use of another ambulance service provider, only the bill for the response vehicle service may be levied as the ILS bill under item 125. Since the ILS tariff already includes transportation, the response vehicle service provider is responsible for the bill for the other ambulance service provider, which will be levied at a BLS rate. This ensures that there is only one bill levied per patient.			
4.3	Should a response vehicle go to a scene and not render any ILS treatment then a bill may not be levied for the said response vehicle.			
	*** PLEASE NOTE:** **VAT cannot be added on the following codes: 102, 103, 111, 125, 127, 129, 131, 133 and 141.** **VAT will only be paid with confirmation of a VAT registration number on the account.**			
Code	**Code Description**	**Practice 13**	**Practice 11**	**Practice 9**
1.	**Basic Life Support** **(Rule 001**: Metropolitan area and long distance codes may not be claimed simultaneously)			
	Metropolitan area (less than 100 kilometres) No invoice may be billed for the distance back to the base in the metropolitan area			
100	Up to 45 minutes	2280.57	2280.57	2280.57
*102	Up to 60 minutes	3074.96	3074.96	3074.96
*103	Every 15 minutes thereafter or part thereof, where specially motivated	769.66	769.66	769.66
	Long distance (more than 100 km)			
*111	Per km DISTANCE TRAVELLED WITH PATIENT	38.31	38.31	38.31
112	Per km NON PATIENT CARRYING KILOMETRES (With maximum of 400 km)	17.22	17.22	17.22
	* Vat Exempted codes			
2.	**Intermediate Life Support** **(Rule 001**: metropolitan area and long distance codes may not be claimed simultaneously)			
	Metropolitan area (less than 100 kilometres) No invoice may be billed for the distance back to the base in the metropolitan area			
*125	Up to 60 minutes	--	4063.73	4063.73
*127	Every 15 minutes thereafter or part thereof, where specially motivated	--	1038.73	1038.73
	Long distance (more than 100 km)			
*129	Per km DISTANCE TRAVELLED WITH PATIENT	--	51.88	51.88
130	Per km NON PATIENT CARRYING KILOMETRES (With maximum of 400 km)	--	17.22	17.22
	* Vat Exempted codes			
3.	**Advanced Life Support/Intensive Care Unit** **(Rule 001**: Metropolitan area and long distance codes may not be claimed simultaneously)			
	Metropolitan area (less than 100 kilometres) No invoice may be billed for the distance back to the base in the metropolitan area			
*131	Up to 60 minutes	--	--	6449.28
*133	Every 15 minutes thereafter or part thereof, where specially motivated	--	--	2105.33
	Long distance (more than 100 km)			
*141	Per km DISTANCE TRAVELLED WITH PATIENT	--	--	93.34
142	Per km NON PATIENT CARRYING KILOMETRES (With maximum of 400 km)	--	--	17.22
	* Vat Exempted codes			

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4.	**ADDITIONAL VEHICLE OR STAFF FOR INTERMEDIATE LIFE SUPPORT, ADVANCED LIFE SUPPORT AND INTENSIVE CARE UNIT**			
151	Resuscitation fee, per incident, for a second vehicle with paramedic and / or other staff (all materials and skills included)	--	--	**7077.10**
	Note: A resuscitation fee may only be billed for when a second vehicle (response vehicle or ambulance) with staff (including a paramedic) attempt to resuscitate the patient using full ALS interventions. These interventions must include one or more of the following: · Administration of advanced cardiac life support drugs. · Cardioversion- synchronised or unsynchronised (defibrillation). · External cardiac pacing. · Endotracheal intubation (oral or nasal) with assisted ventilation. Note applies to both resuscitation by ALS provider and Doctor.			
153	Doctor per hour	--	--	**2033.78**
	Note: Where a doctor callout fee is charged, the name, HPCSA registration number and BHF practice number of the doctor must appear on the Invoice. Medical motivation for the callout must be supplied. Note applies to both resuscitation by ALS provider and Doctor.			
5.	**Aeromedical Transfers**			
	Rotorwing Rates (Wings spins to provide aerodynamic lift e.g. helicopter)			
	Definitions:			
	1. Helicopter rates are determined according to the aircraft type. **2.** Daylight operations are defined from sunrise to sunset (and night operations from sunset to sunrise). **3.** If flying time is mostly in night time (as per definition above), then night time operation rates (type C) should be billed. **4.** The call out charge includes the basic call cost plus other flying time incurred. Staff and consumables cost can only be charged if a patient was treated. **5.** Should a response aircraft respond to a scene (at own risk) and not render any treatment, an invoice may not be levied for the said response. **6.** Flying time is billed per minute but a minimum of 30 minutes applies to the payment. **7.** A second patient is transferred at 50% reduction of the basic call and flight costs, but staff and consumables costs remain billed per patient, only if the aircraft capability allows for multiple patients. Rule 005 must be quoted on the invoice. **8.** Rates are calculated according to time; from throttle open, to throttle closed. **9.** Group A – C must fall within the Cat 138 Ops as determined by the Civil Aviation Authority. **10.** Hot loads are restricted to 8 minutes ground time and must be indicated and billed for separately with the indicated code (time NOT to be included in actual flying time).			
	All published tariffs exclude VAT. VAT can be charged on air ambulances if a VAT registration number is supplied.			
	AIRCRAFT TYPE A: (typically a single engine aircraft)			
	HB206L, HB204/205, HB407, AS360, EC120, MD600, AS350, A119			
	AIRCRAFT TYPE B & Ca (DAY OPERATIONS): (typically a twin engine aircraft)			
	BO105, 206CT, AS355, A109			
	AIRCRAFT TYPE Cb (NIGHT OPERATIONS): (typically a specially equipped craft for night flying)			
	HB222, HB212/ 412, AS365, S76, HB427, MD900, BK117, EC135, BO105			
	AIRCRAFT TYPE D (RESCUE)			
	H500, HB206B, AS350, AS315, FH1100, EC130, S316			
	Air Ambulance : Rotorwing			
Code	**Code Description**	**Practice 13**	**Practice 11**	**Practice 9**
	Rotorwing Type A: Transport			
300	Basic call cost	--	--	**14718.07**
	Plus Flying time	--	--	
301	Cost per minute up to 120 minutes Minimum cost for 30 minutes (R7025,53) applicable	--	--	**234.18**
302	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	**234.18**

303	Hot load (A very quick and rushed load into the aircraft usually at the accident scene), (per minute) – maximum 8 minutes (R1873,47)	--	--	**234.18**
	Rotorwing Type B and C (Day Operations): Transport			
310	Basic call cost	--	--	**25867.87**
	Plus Flying time			
311	Cost per minute up to 120 minutes	--	--	**404.10**
	Minimum cost for 30 minutes (R12122,90) applicable			
312	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	**404.10**
313	Hot load (A very quick and rushed load into the aircraft usually at the accident scene), (per minute) – maximum 8 minutes (R3232,77)	--	--	**404.10**
	Rotorwing Type B and C (Night Operations): Transport			
315	Basic call cost	--	--	**36794.40**
	Plus Flying time			
316	Cost per minute up to 120 minutes	--	--	**404.10**
	Minimum cost for 30 minutes (R12122,90) applicable			
317	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	**404.10**
318	Hot load (A very quick and rushed load into the aircraft usually at the accident scene), (per minute) – maximum 8 minutes (R3232,77)	--	--	**404.10**
	Rotorwing Type A, B and C: Staff and consumables			
320	0 - 30 minutes	--	--	**2282.15**
321	31 - 60 minutes	--	--	**4564.28**
322	61 - 90 minutes	--	--	**6846.66**
323	91 minutes or more	--	--	**9128.54**
	Rotorwing Type D: Transport			
330	Basic call cost	--	--	**31041.10**
	Plus Flying time			
331	Cost per minute up to 120 minutes	--	--	**481.92**
	Minimum cost for 30 minutes (R14457,49) applicable			
332	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	**481.92**
333	Hot load (A very quick and rushed load into the aircraft usually at the accident scene), (per minute) – maximum 8 minutes (R3855,33)	--	--	**481.92**
	Other Cost			
340	Winching (per lift)			**3979.89**
400	Beechcraft Duke	--	--	**80.60**
401	Lear 24F	--	--	**91.49**
402	Lear 35	--	--	**91.49**
403	Falcon 10	--	--	**105.82**
404	King Air 200	--	--	**83.83**
405	Mitsubishi MU2	--	--	**91.49**
406	Cessna 402	--	--	**50.89**
407	Beechcraft Baron	--	--	**43.95**

408	Citation 2	--	--	69.50
409	Pilatus PC12	--	--	69.50
	Fixed wing Group A: Staff cost			
420	Doctor – cost per minute spent with the patient Minimum cost for 30 minutes (R3295,67) applicable	--	--	109.86
421	ICU Registered Nurse – cost per minute spent with the patient Minimum cost for 30 minutes (R1203,90) applicable	--	--	40.13
422	Paramedic – cost per minute spent with the patient Minimum cost for 30 minutes (R1203,90) applicable	--	--	40.13
	Fixed wing Group A: Equipment cost			
430	Per patient – cost per minute Minimum cost for 30 minutes (R981,60) applicable	--	--	32.72
	Fixed wing Group B: Emergency charters			
	1. No staff and equipment fee are allowed. **2.** Cost will be reviewed per case. **3.** Payment of emergency transport will only be allowed if a Group A aircraft is not available within an optimal time period for transportation and stabilisation of the patient.			
450	Services rendered should be clearly specified with cost included. Each case will be reviewed and assessed on merit. ****Only applicable on the date of injury** ****Emergency Inter-Hospital transfers (Pre-Authorised)** ****			
6.	**NATIONALLY APPROVED MEDICATION WHICH MAY BE ADMINISTERED BY HPCSA-REGISTERED AMBULANCE PERSONNEL ACCORDING TO HPCSA-APPROVED PROTOCOLS**			
	Registered Basic Ambulance Assistant Qualification			
	· Oxygen · Entonox · Oral Glucose			
	Registered Ambulance Emergency Assistant Qualification			
	As above, plus · Intravenous fluid therapy · Intravenous dextrose 50% · B2 stimulant nebuliser inhalant solutions (Hexoprenaline, Fenoterol, Sulbutamol) · Ipratropium bromide inhalant solution · Soluble Aspirin			
	Registered Paramedic Qualification			
	As above, plus · Oral Glyceryl Trinitrate · Clopidegrol · Endotracheal Adrenaline and Atropine · Intravenous Adrenaline, Atropine, Calcium, Corticosteroids, Hydrocortisone · Lignocaine, Naloxone, Sodium Bicarbonate 8,5%, Metaclopramide · Intravenous Diazepam, Flumazenil, Furosemide, Glucagon, Lorazepam · Magnesium, Midazolam, Thiamine, Morphine, Promethazine · Pacing and synchronised cardioversion			