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Contents

DEPARTMENT OF EMPLOYMENT AND LABOUR

NO. 7380 **15 April 2026**

AMENDMENT GAZETTE ORTHOTICS AND PROSTHESIS, PRIVATE HOSPITALS 2026-2027

ORTHOTICS AND PROSTHESIS

ORTHOTIC & PROSTHETIC SUPPLY PROTOCOL for 2026/2027 FINANCIAL YEAR
COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

1. Protocols

1.1 Each Medical Service Provider should ensure that the service they provide is compatible with the general procurement guidelines issued by National Treasury.

1.2 The Compensation Fund will bear the reasonable cost for the issue of Orthotic and Prosthetic devices after acquiring an occupational disease or sustaining an injury, provided that liability for the claim has been accepted, the service is prescribed by a medical practitioner, and the prescribed guidelines are followed.

1.3 An employee as defined in the COID Act of 1993, is at liberty to choose their preferred medical service provider and no interference with this is permitted, as long as it is exercised reasonably and without prejudice to the employee or the Compensation Fund. For continuity of service and optimal rehabilitation outcomes it is advised that claimants consult with a medical service provider within their residential province.

1.4 The published gazette on the Orthotic and Prosthetic devices and the tariff of fees will serve as a guideline to determine if any proposed service is reasonable and it will replace all existing tariff structures.

1.5 Pre-authorization by the Compensation Fund is required in **all claims**, even if the devices supplied are listed in the Government Gazette. It is the responsibility of the Medical Service Provider to ensure that liability for the claim has been accepted by the Compensation Fund and that the service is reasonable and in line with the published policy and tariff. All orthotic / prosthetic devices should be suitable for the environment and activity / load level of the employee.

1.6 Replacement of consumable items, refits and repairs must be motivated by the Medical Service Provider. All requests must be accompanied by photos of the Orthotic / Prosthetic Device to be replaced or repaired. Requests must be reasonable and in line with the published policy and tariff.

1.7 The employee, assisted by the Medical Service Provider should complete the appropriate form when requesting replacement, refit or repair of any Prosthetic / Orthotic device. **Refer to Form 6– Request for Orthotic / Prosthetic Services**

1.8 The request for new lower limb prosthetic equipment must be accompanied by a written report by the Medical Service Provider indicating that the employee's functional level has been re-evaluated to take into account any physical or environmental changes encountered by the employee. **Refer to AMPPRO Test for Lower limb amputees.**

1.9 **The request for primary (first time) wheelchair users must be accompanied by a written recommendation from an Occupation Therapist.**

1.10 In exceptional circumstances, if the employment status and / or the functional level of an employee radically changes before a new assistive device is due, a new assistive device

more suitable to the employment conditions and / or functional requirements will be considered by the Compensation Fund.

1.11 If an employee's employment status / functional level changes and an assistive device in a higher category is requested, such higher functional level must be confirmed by the Employer and a rehabilitation team comprising of a Medical Doctor, the Prosthetist, a Physiotherapist and / or an Occupational therapist.

1.12 **The Medical Service Provider must obtain written authorisations for all quotations of Orthotic or Prosthetic devices, refits, consumables, and repairs. Accounts will not be payable for any Orthotic or Prosthetic device supplied to the employee without pre-authorisation and duly completed and signed confirmation of receipt.**

1.13 The Compensation Fund will bear the reasonable cost of repairs to an assistive device which has suffered from "fair" wear and tear of normal use.

1.14 The Compensation Fund will not bear the cost of an orthotic / prosthetic device which is lost, broken, worn out or is otherwise unserviceable as a consequence of an employee's neglect or abuse.

1.15 The Compensation Fund will pay for the refit of a prosthesis strictly only where motivated and justifiable by the circumstances and within the published gazette guidelines. **Refer to Section 4 - Guidelines for Refit**

1.16 Replacement of consumables of Orthotic or Prosthetic devices that may perish or become consumed through reasonable usage will be paid for by the Compensation Fund in line with the supply guidelines. **Refer to Section 3 - Replacement Period Table**

1.17 The Compensation Fund reserves the right in terms of section 42 of the Act to call for a second or independent opinion or evaluation of proposed Orthotic/Prosthetic services.

1.18 Any such report obtained by the Compensation Fund shall state whether the proposed Orthotic/Prosthetic service is appropriate for the diagnosis, functional level, and environmental circumstances of the patient. The Compensation Fund reserves the right to use the information so obtained at its discretion and as is deemed appropriate.

1.19 **The Commissioner is further entitled, pursuant to a complaint by the employee, to call for an independent report concerning any Orthotic/Prosthetic services that have been rendered. The Medical Service Provider should strive to take all reasonable steps to attend to the legitimate complaints of an employee regarding services or assistive devices supplied. If it is found that defective or unsuitable devices (not in line with pre-authorization) have been supplied to an employee, the Medical Service Provider shall replace / repair / alter such devices at no additional cost to the Compensation Fund or the employee**. **The Compensation Fund reserves the right to decide on whether to maintain the said service provider on their data base of service providers or not.**

1.20 The Orthotic and / or Prosthetic devices paid for by the Compensation Fund remains the property of the Compensation Fund. The Orthotic and /Prosthetic devices paid for by the

Compensation Fund is provided to the Recipient as their property, subject to the following conditions: The Recipient acknowledges that the Compensation Fund retains the right, at any reasonable time, to inspect, verify or audit the device to ensure proper use and compliance with programme 4 APP indicator 4.1 requirements. The Recipient may not sell, transfer, or otherwise alienate the device and must solely use it for the purpose for which it was issued.

1.21 Each request for pre-authorization should be accompanied by a quotation on the Medical Service Provider's practice letterhead.

1.22 Every Medical Service Provider should supply the Compensation Fund with the rehabilitation report for all primary amputees.

1.23 Medical Service Providers are required to quote a similar or better component using the same code.

1.24 The Compensation Fund retains the right to verify all products supplied to the employee.

1.25 Acknowledgement of receipt of Orthotic/Prosthetic device should be duly completed and signed by the Medical Service Provider, Injured Employee and Compensation Fund official (Form 8).

1.26 In order for the Compensation Fund to verify that the correct items were supplied, proof of purchase should accompany the acknowledgement of receipt for any single component/item in excess of R50 000.In case where the MSP is also a manufacturer of the component (e.g. specialized wheelchair with special criteria description or custom assistive devices) the warranty letter on official company letter head and signed by an authorized representative must accompany the acknowledgement of receipt (Form 8).

1.27 Should a practice receive notification of supply/fitting of case management and fail to adhere to the request, the preauthorisation in question will be cancelled. The MSP will be temporarily suspended from further preauthorisation until the request is adhered to.

2. Request for Orthotic / Prosthetic Services

The following details must accompany the request for orthotic / prosthetic services:

2.1 Orthotic / Prosthetic Service Request Form (Form 6)

2.2 Motivation for services by Medical Service Provider on practice letterhead

2.3 Quotation by Medical Service Provider according to published tariffs on practice letterhead

2.4 Doctor's Referral letter for any Primary Orthotic / Prosthetic device user

2.5 AMPPRO test (for Lower Limb Prosthesis only)

2.6 Refit report 4.1 – 4.12 (for refit of prosthesis only)

2.7 Quotation according to published tariffs (Form 7)

2.8 Photos of Orthotic / Prosthetic device to be replaced / repaired.

2.9 Certified copy of ID / Valid temporary ID / Passport for foreigners valid within 6 months.

3. Replacement Periods of Medical Orthotic / Prosthetic Equipment

NUMBER	ITEM	PERIOD
3.1	Prosthesis	Every 5 years
	Exceptions:	
	3.1.1. Toe filler	Every Two and half years
	3.1.2. Mid-foot prosthesis	Every Two and half years
	3.1.3. Chopart	Every Two and half years
	3.1.4. Symes	Every Two and half years
	3.1.5. Partial hand	Every Two and half years
	3.1.6. Partial hand opposition post	Every Two and half years
3.2	Refit for prosthesis will be considered within 12 months after fitting of primary amputee with a prosthesis, and refit for returning amputees can be considered after two and half years from the fitting of a new prosthesis	
3.3	Silicone liners, gel liners	Two per year
3.4	Suspension sleeves	Two per year
3.5	Distal volume cup	Two per year
3.6	Prosthetic socks	Twelve per year
	3.6.1. If worn with silicone or gel liners	Six per year
3.7	Prosthetic sheath	Twelve per year
	3.7.1. If worn with silicone or gel liners	Six per year
3.8	Cosmetic stockings	Three pairs per year
3.9	Cosmetic foam cover	One per year.
3.1	Cosmetic glove	One per year
3.11	Callipers	Every Two Years
3.12	Manual Wheelchairs	Every Three Year
3.13	Motorized Wheelchairs	Every Five years
3.14	Major Repairs to Motorized Wheelchairs	Every Two and a half years.
3.15	Wheelchair cushions	Two per year
3.16	Motorized wheelchair batteries	One pair every 6 months
3.17	Orthopaedic footwear	Two pairs per year
3.18	Footwear modifications	Three modifications per year
3.19	Compression stockings	Four pairs per year
3.20	Off the shelf orthosis	Two per year

4. Guidelines for Refit:

This guideline covers Prosthetic devices that require refit of the socket after the initial issue. Full motivation with a report indicating the following details must be submitted:

4.1 Date of amputation
4.2 Date when the present prosthesis was fitted.
4.3 Description of the prosthesis
4.4 Residual limb measurements when prosthesis was fitted.
4.5 Symptoms indicating loss of fit.
4.6 Diagnosis of loss of fit
4.7 Current residual limb measurements.
4.8 Number and thickness of prosthetic socks worn by employee
4.9 Condition of prosthesis
4.10 The employee's current activity level
4.11 An opinion as to the suitability of the employees' current prosthesis
4.12 Photos of the prosthetic device to be refit / repaired.

5. Functional Level

A determination of the medical necessity for certain components / additions to a prosthesis is based on the potential functional ability of the employee. Potential functional ability is defined as the reasonable expectation of the rehabilitation team including a Medical Doctor, the Prosthetist, a Physiotherapist and / or an Occupational therapist and the employee based on

- history including prosthetic use.
- current condition including the status of the residual limb and other medical factors.
- employment status
- desire to ambulate.

The clinical assessment for Lower Limb amputees should be based on the AMPPRO test results.

FORM 6
ORTHOTIC / PROSTHETIC SERVICE REQUEST FORM

Employee Details		
Name		
Surname		
Claim number		
Date of accident		
ID/Passport number		
Residing Province		
Physical address		
Employee contact number		
Alternative contact name (family/friend)		
Alternative contact (family/friend) number		
Employee e-mail address		
Employee to state why service is required and date of last issue		
Would you like to be contacted with regards to the Compensation Fund`s return to work programme?		**Yes / No**
Employee signature		
Medical Service Provider Details		
Type of Orthotic / Prosthetic Device prescribed (Attach Diagnosis Specific Forms):		

Practice name:	
Practice number:	
Treating Medical Service Provider Name and Surname:	
HPCSA number:	
Contact number:	
Email address	
Signature	
Date:	
Employment History of Injured Employee	
Current Employer	
Employer/Company Name	
Responsible Manager	

Contact number	
E-mail address	
Previous Employer	
Employer/ Company Name	
Responsible manager	
Contact number	
Email address	

FORM 7 PROSTHETIC / ORTHOTIC DEVICE QUOTATION:

Employee: _____ Claim Number: _____

Diagnosis:

_____

_____

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_____

_____

_____

Code	Description	Amount excl VAT.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____	_____	_____
_____	_____	_____

Remarks:

Treating Medical Service

Service Provider Signature:	Employee Signature:
Print name:	Print name:
Date:	Date:

DIAGNOSIS SPECIFIC FORMS

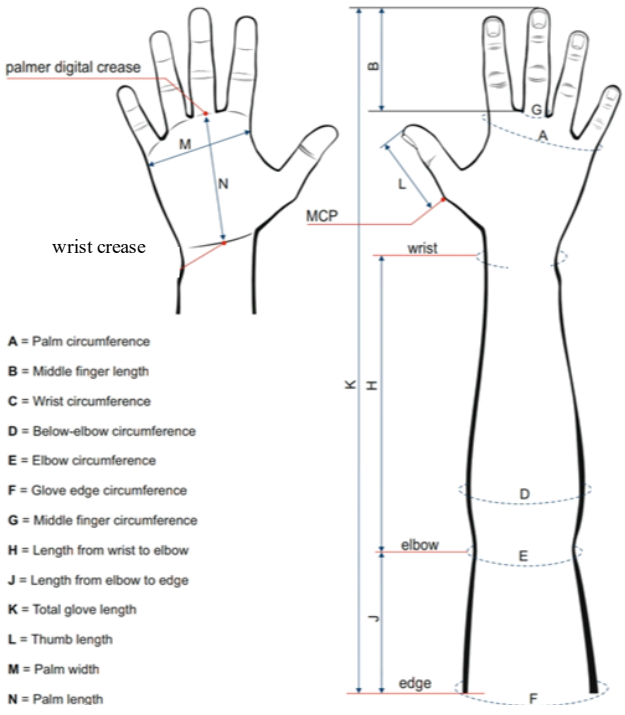
Partial Hand Prosthesis

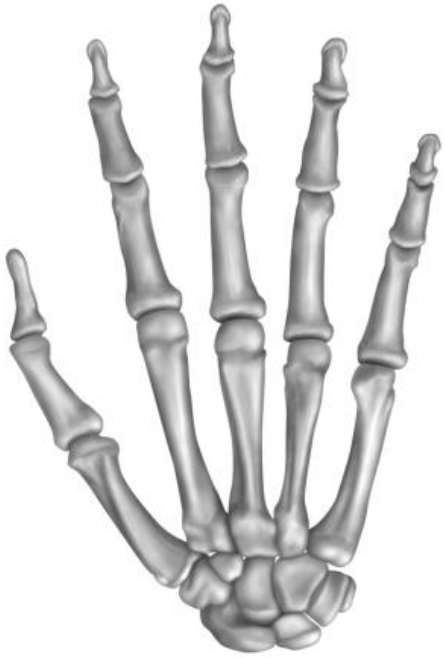
Employee name and surname: _____

Claim number: _____

**** Provide quotation and motivation on practice letter head – all prices excl VAT as per specific financial year's gazette**

Amputation side	**Left / Right**		
Dominant hand	**Left / Right**		
Pictures included? (Mandatory)	**Yes / No**		
Comments:			
Sound side measurements as illustrated below			
A		**H**	
B		**I**	
C		**K**	
D		**L**	
G		**M**	
		N	
Date of last prosthetic issue			
Which Prosthetist issued employee's previous prosthesis?			
Desired activities employee wants to achieve with the prosthesis			





Highlight / colour in amputated site.

Occupational therapist rehabilitation proposal and quotation included for primary amputee?	**YES**	**NO**
Comment:		

Comments:

_____
_____
_____
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_____
_____
_____
_____
_____
_____

Prosthetist Signature:

Print name:

Date:

Employee Signature:

Print name:

Date:

WRIST DISARTICULATION / TRANS RADIAL

Employee name and surname: _____

Claim number: _____

**** Provide quotation and motivation on practice letter head – all prices excl VAT as published in specific financial year's gazette**

Amputation side		**Left / Right**			
Dominant hand		**Left / Right**			
Pictures included? (Mandatory)		**Yes / No**			
Comments:					
Measurements					
Sound side			**Residual limb**		
Olecranon to end of middle finger	**mm**		**Olecranon to end of stump**	**mm**	
Olecranon to wrist	**mm**		**Circumference measurements taken in ___ increments (starting distal)**	**mm**	
Wrist circumference	**mm**		**ML Condyles**	**mm**	
Forearm circumference	**mm**		**ML Above condyles**	**mm**	
Residual limb drawing:			**1**	**mm**	
			2	**mm**	
			3	**mm**	
			4	**mm**	
			5	**mm**	
			Limitation in elbow ROM?	**Yes**	**No**
Skin graph	**Y/N**	**Bony prominences**	**Y/N**	**Scar tissue**	**Y/N**
Date of last prosthetic issue					
Which Prosthetist issued employee's previous prosthesis?					
Desired activities employee wants to achieve with the prescribed prosthesis					

Comments:

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Prosthetist Signature:

Print name:

Date:

Employee Signature:

Print name:

Date:

ELBOW DISARTICULATION / TRANS HUMERAL

Employee name and surname: _____

Claim number: _____

**** Provide quotation and motivation on practice letter head – all prices excl VAT as per specific financial year's gazette**

Amputation side		**Left / Right**			
Dominant hand		**Left / Right**			
Pictures included? (Mandatory)		**Yes / No**			
Comments:					
Measurements					
Sound side			**Residual limb**		
Olecranon to end of middle finger	**mm**		**Acromion to end of stump**	**mm**	
Olecranon to wrist	**mm**		**Axilla to and of stump**	**mm**	
Wrist circumference	**mm**				
Forearm circumference	**mm**				
Acromion to elbow joint	**mm**		**Circumference measurements taken in ___mm increments (starting distal)**		
Residual drawing:			**1**	**mm**	
			2	**mm**	
			3	**mm**	
			4	**mm**	
			5	**mm**	
			Limitation in Shoulder ROM?	**Yes**	**No**
Skin graph	**Y/N**	**Bony prominences**	**Y/N**	**Scar tissue**	**Y/N**
Date of last prosthetic issue					
Which Prosthetist issued patient's previous prosthesis?					
Desired activities employee wants to achieve with the prescribed prosthesis					

Comments: _____

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Prosthetist Signature:

Print name:

Date:

Employee Signature:

Print name:

Date:

SHOULDER DISARTICULATION

Employee name and surname: _____

Claim number: _____

**** Provide quotation and motivation on practice letter head – all prices excl VAT as per specific financial year's gazette**

Amputation side	**Left / Right**				
Dominant hand	**Left / Right**				
Pictures included? (Mandatory)	**Yes / No**				
Comments:					
Measurements					
Sound side					
Olecranon to end of middle finger	**mm**	**Acromion to elbow joint**	**mm**		
Olecranon to wrist	**mm**	**Mid-humeral circumference**	**mm**		
Wrist circumference	**mm**				
Forearm circumference	**mm**				
Acromion to elbow joint	**mm**	**Circumference measurements taken in ___mm increments (starting distal)**			
Residual limb drawing:					
Skin graph	**Y/N**	**Bony prominences**	**Y/N**	**Scar tissue**	**Y/N**
Date of last prosthetic issue					
Which Prosthetist issued employee's previous prosthesis?					
Desired activities employee wants to achieve with prescribed prosthesis					

Comments:

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Prosthetist Signature:	**Employee Signature:**
Print name:	**Print name:**
Date:	**Date:**

MANUAL WHEELCHAIR

Employee name and surname: _____

Claim number: _____

**** Provide quotation and motivation on practice letter head – all prices excl VAT as per specific financial year's gazette**

INJURY				
Diagnosis				
Level of injury				
Brief description of patient activity profile				
Date of last wheelchair issue				
Which MSP issued employee's previous wheelchair				
Postural deformities				
	Fixed		**Correctable**	
	Scoliosis		Kyphosis	
	Lordosis		Gibbus	
	Anterior pelvic tilt		Posterior pelvic tilt	
	Pelvic rotation		Pelvic obliquity	
	Joint contractures		Hip dislocation	
Comments				
Skin integrity				
Pain				
Other comments				
Pictures included? (Mandatory)	Y / N			

ENVIRONMENTAL ASSESSMENT								
Residential area	**Rural**		**Informal**		**Suburban**			
Terrain accessed mostly	**Even**		**Slopy**		**Rocky**		**Sandy**	
Toilet accessibility	**Yes**				**No**			
Mode of transport	**Private**		**Public**		**Other**			
Comments:								

WHEELCHAIR MEASUREMENTS								
Knee to ground								
Seat width								
Seat length								
Backrest height								
Leg length discrepancy	**Yes / No**							
Types tyres required as per level of injury and terrain	**Castor wheels**	Pneumatic		Solid				
	Rear wheels	Pneumatic		Solid				
Push rim requirement								
Type of cushion as per level of injury	**Gel**		**Air**		**Hybrid**		**Foam**	
Transfer board needed	**Yes**			**No**				
Comments and other devices needed								

Treating Medical Service

Provider Signature: **Employee Signature:**

Print name: **Print name:**

Date: **Date:**

MOTORIZED WHEELCHAIR

Employee name and surname: _____

Claim number: _____

**** Provide quotation and motivation on practice letter head – all prices excl VAT as per specific financial year's gazette**

INJURY				
Diagnosis				
Level of injury				
Brief description of patient activity profile				
Date of last wheelchair issue				
Which MSP issued employee's previous wheelchair				
Postural deformities	**Fixed**		**Correctable**	
Comments	Scoliosis		Kyphosis	
	Lordosis		Gibbous	
	Anterior pelvic tilt		Posterior pelvic tilt	
	Pelvic rotation		Pelvic obliquity	
	Joint contractures		Hip dislocation	
Skin integrity				
Pain				
Other comments:				
Pictures included? (Compulsory)	Y / N			

ENVIRONMENTAL ASSESSMENT								
Residential area	**Rural**		**Informal**		**Suburban**			
Terrain accessed mostly	**Even**		**Sloppy**		**Rocky**		**Sandy**	
Toilet accessibility	**Yes**				**No**			

Mode of transport	**Private**		**Public**		**Other**		
Comments:							
WHEELCHAIR MEASUREMENTS							
Knee to ground							
Seat width							
Seat length							
Backrest height							
Leg length discrepancy	**Yes**						
	No						
Types tyres required as per level of injury and terrain	**Castor wheels**	Pneumatic		Solid			
	Rear wheels & size						
Type of cushion as per level of injury	**Gel**		**Air**		**Hybrid**		**Foam**
Transfer board needed	**Yes**		**No**				
Comments and other devices needed							
Chin / Hand control	**Left**		**Right**				

Comments:

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Treating Medical Service

Provider Signature: **Employee Signature:**

Print name: **Print name:**

Date: **Date:**

HIP DISARTICULATION / HEMI-PELVECTOMY

Employee name and surname: _____

Claim number: _____

***Filled and signed AMPPRO / AMPnoPRO sheet mandatory with submission**
**** Bilateral Primary amputees are categorized as Activity level 2 and do not require an AMPnoPRO)**
**** Provide quotation and motivation on practice letter head – all prices excl VAT as per specific financial year's gazette**

Amputation side		**Left / Right / Bilateral**	**AMPPRO score: Activity level: 1 / 2 / 3 / 4 Comment:**		
Weight of patient		**kg**			
Pictures included? (Mandatory)		**Yes / No**			
Measurements					
Sound side			**Residual limb**		
CK to ground		**mm**	**Ischium to ground**	**mm**	
			Over iliac crest	**ML -**	**AP -**
			Above iliac crest	**ML -**	**AP -**
Shoe size		**mm**	**Circumference over iliac crest**		
Thigh circumference		**mm**			
Calf circumference		**mm**	**Circumference above iliac crest**		
Ankle circumference		**mm**			
Skin graph	**Y/N**	**Bony prominences**	**Y/N**	**Scar tissue**	**Y/N**
Residual type	**Bony**	**Fleshy**	**Muscular**	**Severely atrophied**	
Date of last prosthetic issue					
Which Prosthetist issued employee's last prosthesis?					
Desired activities employee wants to achieve with prescribed prosthesis					

Comments:

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Prosthetist Signature:

Print name:

Date:

Employee Signature:

Print name:

Date:

TRANS FEMORAL / KNEE DISARTICULATION

Employee name and surname: _____

Claim number: _____

***Filled and signed AMPPRO / AMPnoPRO sheet mandatory with submission**
**** Bilateral Primary amputees are categorized as Activity level 2 and do not require an AMPnoPRO**
**** Provide quotation and motivation on practice letter head – all prices excl VAT as per specific financial years gazette**

Amputation side		**Left / Right / Bilateral**	**AMPPRO score: Activity level: 1 / 2 / 3 / 4 Comment:**		
Weight of employee		**kg**			
Pictures included? (Mandatory)		**Yes / No**			
Measurements					
Sound side			**Residual limb**		
CK to ground		**mm**	**Ischium to end of stump (TF)**		**mm**
			End of stump to ground (TF)		**mm**
			Femoral condyles (TK)	**ML - AP -**	
			Above femoral condyles (TK)	**ML - AP -**	
Shoe size		**mm**	**Liner size**		
Thigh circumference		**mm**	**Measurements taken with / without liner?**		
Calf circumference		**mm**	**Circumference measurements taken in ___mm increments (starting distal)**		
Ankle circumference		**mm**	**1**		**mm**
Residual drawing:			**2**		**mm**
			3		**mm**
			4		**mm**
			5		**mm**
			6		**mm**
			Limitation in Hip ROM?	**Yes**	**No**
Skin graph	**Y/N**	**Bony prominences**	**Y/N**	**Scar tissue**	**Y/N**
Residual type	**Bony**	**Fleshy**	**Muscular**	**Severely atrophied**	
Date of last prosthetic issue					
Which Prosthetist issued employee's previous prosthesis?					
Desired activities employee wants to achieve with the prescribed prosthesis					

Comments:

_____

Prosthetist Signature:

Print name:

Date:

Employee Signature:

Print name:

Date:

TRANS TIBIAL / SYMES

Employee name and surname: _____

Claim number: _____

***Filled and signed AMPPRO / AMPnoPRO sheet mandatory with submission**
**** Bilateral Primary amputees are categorized as Activity level 2 and do not require an AMPnoPRO**
**** Provide quotation and motivation on practice letter head – all prices excl VAT as per specific financial year's gazette**

Amputation side		**Left / Right / Bilateral**	**AMPPRO score:** **Activity level: 1 / 2 / 3 / 4** **Comment:**		
Weight of employee		**kg**			
Pictures included? (Mandatory)		**Yes / No**			
Measurements					
Sound side			**Residual limb**		
CK to ground		**mm**	**Tibial plateau to end of stump**		**mm**
			End of stump to ground		**mm**
			Over Malleolus (Symes)	**ML -**	**AP -**
			Above Malleolus (Symes)	**ML -**	**AP -**
Shoe size			**Liner size (TT)**		
			Measurements taken with / without liner?		
Calf circumference		**mm**	**Circumference measurements taken in ___mm increments (starting distal)**		
Ankle circumference		**mm**	**1**		**mm**
Residual drawing:			**2**		**mm**
			3		**mm**
			4		**mm**
			5		**mm**
			6		**mm**
			Limitation in knee ROM?	**Yes**	**No**
Skin graph	**Y/N**	**Bony prominences**	**Y/N**	**Scar tissue**	**Y/N**
Residual type	**Bony**	**Fleshy**	**Muscular**	**Severely atrophied**	
Date of last prosthetic issue					
Which Prosthetist issued employee's previous prosthesis?					
Desired activities employee wants to achieve with the prescribed prosthesis					

Comments:

_____
_____
_____
_____
_____
_____
_____

Prosthetist Signature:

Print name:

Date:

Employee Signature:

Print name:

Date:

PARTIAL FOOT / ORTHOPAEDIC SHOE

Employee name and surname: _____

Claim number: _____

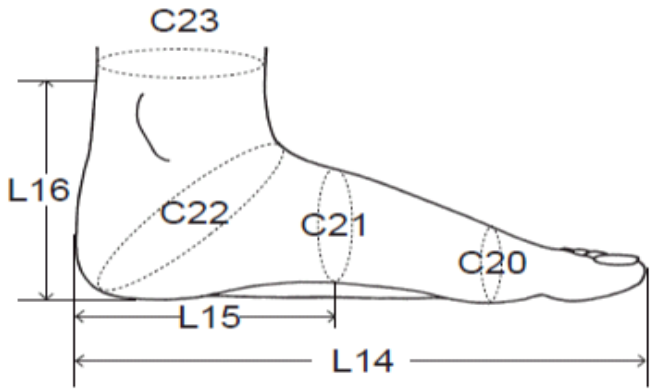
***Filled and signed AMPPRO / AMPnoPRO sheet mandatory with submission (Prosthetics only)**
**** Bilateral Primary amputees are categorized as Activity level 2 and do not require an AMPnoPRO**

**** Provide quotation and motivation on practice letter head – all prices excl VAT as per specific financial year's gazette**
***** For orthopaedic shoes and partial foot prosthesis photographs of the following is needed:**

1. **Amputated foot / residual limb (from anterior and posterior)**
2. **Effected limb together with sound limb (anterior)**

Amputation / Injury side	**Left / Right / Bilateral**	**AMPPRO score:** **Activity level: 1 / 2 / 3 / 4** **Comment:**	
Weight of employee	**kg**		
Pictures included? (Mandatory)	**Yes / No**		

Measurements



Sound side			**Residual / Effected limb**		
Circumference C20		**mm**	**Circumference C20**		**mm**
Circumference C21		**mm**	**Circumference C21**		**mm**
Circumference C22		**mm**	**Circumference C22**		**mm**
Circumference C23		**mm**	**Circumference C23**		**mm**
Length L14		**mm**	**Length L14**		**mm**
Length L15		**mm**	**Length L15**		**mm**
Length L16		**mm**	**Length L16**		**mm**
Skin graph	**Y/N**	**Bony prominences**	**Y/N**	**Scar tissue**	**Y/N**
Residual type	Bony	Fleshy	Muscular	Severely atrophied	
Ankle evaluation			Contractures present	Y / N	
Active dorsiflexion		Y / N	Active plantarflexion	Y / N	
Date of last prosthesis /					

shoe issued	
Which Prosthetist issued employee's previous prosthesis / shoe?	
Desired activities employee wants to achieve with the prescribed device?	

Comments:

Prosthetist Signature:

Print name:

Date:

Employee Signature:

Print name:

Date:

FORM 8

CONFIRMATION OF RECEIPT OF ORTHOTIC / PROSTHETIC DEVICE.

Claim number _____

1. Confirmation of manufacture / supply by Medical Service Provider:

This serves to confirm that I have manufactured and supplied the following for the above-mentioned employee, as per approval from the office of the Compensation Fund dated _____

Service provider: _____

Practice number: _____

Signature: _____

Date: _____

2. Confirmation of receipt by employee:

I confirm that I have received the correct Orthotic / Prosthetic device and / or accessories and I am satisfied that it is in good working condition, to the value of R _____.

Name: _____

Signature: _____

Date: _____

Telephone number: _____

3. Confirmation of receipt of Orthotic / Prosthetic device by the provincial case manager:

Name: _____

Signature: _____

Date: _____

This form should be completed and submitted to the Compensation Fund by the Medical Service Provider for payment with the account, a copy of the initial quotation, photos of the orthotic / prosthetic device supplied and the letter of approval from the Compensation Fund.

Description Change to a Tariff Code

AMENDMENT PROSTHETICS TARIFF OF FEES AS FROM 01 APRIL 2026 (PRACTICE 87 & 90)					
Item	**Code**	**K Level**	**Prosthetic Consultation**		**Rand (excl. VAT)**
			Single axis (Monocentric)		
PK051	**A20051**	2,3,4	Monocentric Knee Hydraulic controlled **(Special criteria)**	ea	**83,613.33**

PRIVATE HOSPITAL

AMENDMENT PRIVATE HOSPITAL GAZETTE (PR 49 & 79) FROM 01 APRIL 2026			
TARIFF CODE	**DESCRIPTION**		
*	**Can be claimed by a facility**		
-	**Cannot be claimed by a facility**		
11. SUB-ACUTE REHABILITATION HOSPITALS (PR 49)			
Rule. Item H020 may not be billed with item H950 or H955			
11.1 General Wards			
H020	Sub-Acute Rehabilitation ward per day. **N.B**.Item **H020** may not be billed with item **H950**	**4,468.57**	-
H950	Frail care/Hospice ward (Daily) (Inclusive fee: ward fee, general care management, Doctors, Nursing staff) **N.B**.Item **H950** may not be billed with item **H020**	**2,598.03**	
13. FRAIL CARE / PALLIATIVE / HOSPICE (PR 79)			
13.1 General Wards			-
H950	Frail care/Hospice ward (Daily) (Inclusive fee: ward fee, general care management, Doctors, Nursing staff) **N.B**.Item **H950** may not be billed with item **H955 or H020**	**2,598.03**	
H955	Home health care, per visit.	**620.87**	

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