DEPARTMENT OF EMPLOYMENT AND LABOUR

NO. 7259 **20 March 2026**

PRIVATE HOSPITAL GAZETTE 2026

employment & labour

Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

Private Hospitals Gazette Table of Content

Compensation Fund

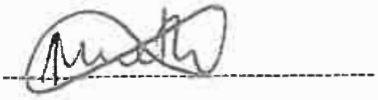
COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (ACT No. 130 OF 1993), AS AMENDED

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

employment & labour

Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

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)
  c 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)

employment& labour
Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

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 io 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.

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.

- AU 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.

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:
  - o Confirm the clinical description of the injury or disease.
  - o Detail all procedures performed; and
  - o 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);

- 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

- o 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.

c 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

- 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. Registerwith the Compensation Fund as an employer where applicable in terms of the COIDAct 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.

employment & labour

Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

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 tvoe = 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	
R	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	Emolovee surname	20	Alpha	
7	Emolovee initials	4	Alpha	
R	Emolovee Names	20	Alpha	
r<r	BHF Practice number	15	Alpha	
10	Switch ID	3	Numeric	
11	Patient reference number laccount number	11	Alpha	
12	Tvoe of service	1	Alpha	
13	Service date iCCYYMMDD)	8	Date	
14	Quantity / Time in minutes	7	Decimal	
15	Service amount	15	Decimal	A
16	Discount amount	15	Decimal	
17	Description	30	Alpha	
18	Tariff	10	Alpha	1
19	Service fee	1	Numeric	1
20	Modifier 1	5	Alpha	
21	Modifier 2	5	Alpha	
22	Modifier 3	5	Alpha	1
23	Modifier 4	5	Alpha	1
24	Invoice Number	10	Alpha	1
25	Practice name	40	Alpha	1
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	A
32	Authorisation number	21	Alpha	
33	Resubmission flao	5	Alpha	
34	Diagnostic codes	64	Alpha	

employment& labour

Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

FIELD	DESCRIPTION	Max Length	DATA TYPE	MANDATORY
35	Treating Doctor BHF practice number	9	Alpha	
36	Dosage duration ifor medicine/	4	Alpha	
37	Tooth numbers		Alpha	
38	GenderfM, F)	1	Alpha	
39	HPCSA number	15	Alpha	
40	Diagnostic code type	1	Alpha	
41	Tariff code tvoe	1	Alpha	
42	CPT code *1* 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: Readinc 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 (CCYYMMDDi	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 ICCYYMMDDI	8	Date	
65	Treatment Time (HHMMi	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 i.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	

employment & labour

Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

MSPs PAID BY THE COMPENSATION FUND

Discipline Code:	Discipline Description:
004	Chiropractors
009	Ambulance Services - Advanced
010	Anesthesiology
1011	Ambulance Services - Intermediate
1012	Dermatology
1013	Ambulance Services - Basic
014	General Medical Practice
1015	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

employment& labour

Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

078	Blood transfusion services
079	Hospices/Frail Care
082	Speech therapy and Audiology
083	Hearino 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.

PRIVATE HOSPITAL GAZETTE 2026

PRIVATE HOSPITALS PERDIEM TARIFF OF FEES FROM 1 APRIL 2026
Private Hospital Rules
"NOTE: • Fees include VAT • Submission of running account is not allowed. i:e Hospitals are requested to submit a monthly invoice for patients admitted for a prolonged period. **(Service dates claimed for should not overlap to the following month.)** **NB! All invoices where a patient was admitted should be accompanied by some kind of hospital record as proof of admission. The hospital record may take a form of ,but not limited to an admission /discharge forms/record submitted and must be on a hospital letter head.**
Acute Hospital Accommodation
The day admission fee shall be charged in respect of all patients admitted as day patients and discharged before 23:00 on the same date. Ward fees shall be charged at the full day rate if admission takes place before 12:00 and at the half daily rate if admission takes place after 12:00. At discharge, ward fees shall be charged at half the daily rate if the discharge takes place before 12:00 and the full daily rate if the discharge takes place after 12:00 Ward fees are inclusive of all pharmaceuticals and equipment that are provided in the accommodation, theatre, emergency room and procedure rooms Drugs, consumables and disposable items used during a procedure or issued to a patient on discharge should be claimed for using the appropriate code.
Day Hospital Admissions
Day admission: Chargeable for all patients admitted and discharged before midnight on the same day irrespective of the time of admission. **Overnight Fee:** Applicable to licenced day hospitals only. Charged for cases with complications the maximum of one night. A medical report from the treating doctor indicating reasons for extended of stay must accompany an invoice.
Special Care Units
Hospitals shall obtain a treating doctor's report stating the reason for accommodation in an intensive care unit or a high care ward. The report must include the date and time of admission and discharge from the unit. The report must be forwarded to the Fund together with the invoice. Pre-drafted and standard certificates of authorisation will not be acceptable.

Theatres and Emergency Units
Theatre and Emergency fees are inclusive of all consumables and equipment. The after hours fee are included in the normal theatre fee. A copy of the treating doctor's medical report must be submitted, for treatment provided in emergency units for codes H301, H302 and H303. Emergency fee - excludes follow-up visits.
Minor Theatre Fee
This shall refer to : A facility where simple procedures, which require limited instrumentation and drapery, minimum nursing input and local anaesthetic procedures are carried out. No sophisticated monitoring is required but resuscitation equipment must be available. The exact time of admission to and discharge from the minor theatre must be stated.
Major Theatre Fee
This shall refer to : A facility where major procedures are performed under general and local anaesthesia. The exact time of admission to and discharge from the theatre must be stated.
Prosthesis Pricing
A ceiling price of **R1843.68** per prosthesis is included in the theatre tariff. The combined value of all the components including cement in excess of **R1843.68** should be charged separately. A prosthesis is a fabricated or artificial substitute for a diseased or missing part of the body, surgically implanted, and shall be deemed to include all components such as pins, rods, screws, plates or similar items, forming an integral part of the device so implanted, and shall be charged as a single unit. Reimbursement will be at the lowest available manufacturer's price (inclusive of VAT). List of items to be reflected in the invoice.

Internal Fixators (surgically implanted)
Reimbursement will be at the lowest available manufacturer's price inclusive of VAT. Hospitals / unattached operating theatre units shall show the name and reference number of each item. The suppliers invoices, each containing the manufacture's name, including the components specified should be attached and appear on the medical invoice. List of items to be reflected in the invoice.
External Fixators
Reimbursement will be at 33% of the lowest available manufacturer's price inclusive of VAT. List of items to be reflected in the invoice.
[MEDICAL ARTIFICIAL ITEMS (non-prosthesis)
Hospitals / unattached operating theatre units shall show the name and reference number of each item. The suppliers' invoices, each containing the manufacturer's name, including the components specified should be attached and appear on the medical Invoice. List of items to be reflected in the invoice.
Serious Burns (Acute Hospitals PR 57/58)
Billed at normal fee for service. Codes H289 and H290 are applicable and must be accompanied by a medical report from the treating doctor. TTO's should be charged according to code H288. List of items to be reflected in the invoice.
TTO
TTO issued on discharge, and will be reimbursed by the Fund. List of items to be reflected in the invoice.

Acute and Sub-Acute Rehabilitation
Maximum period for a patient stay at Acute rehabilitation (Practice 59) ward is 3 months (12 weeks), then the patient should be discharged or referred to Sub-acute rehabilitation (Practice 49). For all patients transfered from Acute Rehabilitation to Sub-acute Rehabilitation, a referral letter from the treating doctor is required by the Fund. All Sub-acute rehabilitation facilities must have a rehabilitation plan for all patients admitted.
General Ward For Acute Rehabilitation Hospitals
All patients transfered from Acute hospital (Practice 57/58), Acute Rehabilitation (Practice 59) or Sub-acute Rehabilitation (Practice 49), a referral letter is required from the treating doctor. Ward fees shall be charged at the full daily rate if admission takes place before 12:00 and at the half daily rate if admission takes place after 12:00. At discharge, ward fees shall be charged at half the daily rate if the discharge takes place before 12:00 and the full daily rate if the discharge takes place after 12:00. Ward fees are inclusive of all pharmaceuticals and equipment that are provided in the accommodation and procedure rooms.
Sub - Acute Rehabilitation Hospitals
Admission to the facility should be referred by the treating doctor. Ward fees shall be charged at the full daily rate if admission takes place before 12:00 and at the half daily rate if admission takes place after 12:00. At discharge, ward fees shall be charged at half the daily rate if the discharge takes place before 12:00 and the full daily rate if the discharge takes place after 12:00. Ward fees are inclusive of all pharmaceuticals and equipment that are provided in the accommodation and procedure rooms.
Frail Care / Paliative / Hospice (Pr 79)
Hospice or similar approved facilities. All patients transfered from Acute hospital, Acute Rehabilitation or Sub-acute Rehabilitation, a referral letter from the treating doctor is required.

PRIVATE HOSPITAL PERDIEM TARIFF OF FEES FROM 01 APRIL 2026			
TARIFF CODE	**DESCRIPTION**	**ACUTE HOSPITAL (PR 57/58)**	**DAY HOSPITAL (PR 77)**
*	**Can be claimed by a facility**		
	Cannot be claimed by a facility		
1. General Wards			
H001	Surgical cases: per day	**4,902.02**	**-**
H002	Thoracic and neurosurgical cases (including laminectomies and spinal fusion): per day	**4,902.02**	**-**
H004	Medical and neurological cases: per day	**4,902.02**	**-**
H007	Day admission which includes all patients discharged by 23:00 on date of admission	**2,015.77**	**-**
H014	Overnight fee - for complications only (maximum of one night)	**-**	**1,995.61**
H100	Day admission which includes all patients discharged by 23h00 on date of admission	**-**	**1,995.61**
1.1 Special Care Units			
H201	Intensive Care Unit: per day	**29,953.59**	**-**
H215	High Care Ward: per day	**15,457.44**	**-**
2. Theatres and Emergency Unit			
H301	For all emergencies including those requiring basic nursing input, e.g. BP measurement, urine testing, application of simple bandages, administration of injections.	**1,130.58**	**1119.16**
H302	For all emergencies which require the use of a procedure room, e.g. for application of plaster, stitching of wounds.	**2,293.71**	**2270.77**
H105	Resuscitation fee charged only if patient has been resuscitated and intubated in a trauma unit.	**8,975.69**	-

3. Follow up visit			
H303	Follow-up visits; The Fund will reimburse hospitals for all materials used during follow-up visits. No consultation or facility fee is chargeable. The account is to be billed as for fee for service.	*	-
4. Minor Theatre Fee			
H071	Charge per minute	**136.21**	**136.21**
5. Major Theatre Fee			
H081	Charge per minute	**403.07**	**399.04**
6. Prosthesis			
H286	Internai/external Fixators (surgically implanted)		**-**
7. Medical Artificial Items (non-prosthesis)			
H287	Examples of items included hereunder shall be artificial limbs, wheelchairs, crutches and excretion bags. Copies of invoices shall be supplied to the Fund. Reimbursement will be at the lowest available manufacturer's price inclusive of VAT. Further Non-Prosthetic Medical Artificial items: □ Sheepskins □ Abdominal Binders □ Orthopaedic Braces (ankle, knee, wrist, arm) □ Anti-Embolism Stockings □ Future Supports □ Corsets □ Crutches □ Clavicle Braces □ Toilet Seat Raisers □ Walking Aids □ Walking Sticks □ Back Supports □ Elbow / Hand Cradles		

8. Serious Burns			
H289	Serious Burns: Fee for service (Inclusive of all services e.g. accommodation, theatre, etc.) except medication whilst hospitalised.		-
H290	Serious Burns: Item for medication and material used during hospitalisation excluding the TTO's. NB!! List of items used to be reflected in the invoice.	★	-
9. TTO			
H288	Treatment Taken Out issued at discharge		■
10. ACUTE REHABILITATION HOSPITALS (PR 59)			
10.1 General Wards			
H010	General Rehabilitation ward per day.	**8,189.01**	-
10.2 TTO			
H288	Treatment Taken Out issued at discharge		-
11. SUB-ACUTE REHABILITATION HOSPITALS (PR 49)			
11.1 General Wards			
H020	Sub-Acute Rehabilitation ward per day.	**4,468.57**	-
11.2 TTO			
H288	Treatment Taken Out issued at discharge		-
12. PSYCHIATRIC HOSPITAL (PR 55)			
12.1 General Wards			
H008	General Ward for Psychiatric Hospitals.	**3,818.89**	-
12.2 TTO			
H288	TreatmentTaken Out issued at discharge		-
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)	**2,598.03**	-
H955	Home health care, per visit	**620.87**	-
13.2 TTO			
H288	Treatment Taken Out issued at discharge	A	-