

Transfer Certificate Details (TCD) - Data Dictionary v1.4 20191125

Root Element: transferCertificateDetails

Segment Name: header

Data Element	Obligation	Format	Size	Repetition	Description	Conditions
Segment	Mandatory			1	The header segment contains the type of message, the Health Fund information (both the OLD and NEW Health Fund) and transactional information.	Transfer Certificate Details (TCD) cannot be sent if a Transfer Certificate Request (TCR) has not been received from the NEW Health Fund. Transfer Certificate Details (TCD) cannot be sent if a Transfer Certificate Cancellation Request (TCC) has been received from the NEW Health Fund.
schemaVersion	Mandatory	N	4	1	The schema version is a two-level number (##.##) that will be used to denote the version of the XML Schema used to validate the XML file, for example 1.0.	
contentType	Mandatory	A	3	1	The type of transaction. TCD = Transfer Certificate Details	
originFundBrandId	Mandatory	A	3	1	This is the originFundBrandId that is supplied in the associated Transfer Certificate Request (TCR).	
fundBrandId	Mandatory	A	3	1	This is the fundBrandId that is supplied in the associated Transfer Certificate Request (TCR). This will be equivalent to industry Health Fund code for the OLD Health Fund i.e. the Health Fund that is sending the TCD response.	
transactionId	Mandatory	A/N	24	1	The transactionId that is supplied in the associated Transfer Certificate Request (TCR). This is a unique identifier that is allocated by the initiating Health Fund. The transaction ID will be consistent throughout the entire lifecycle of the Transfer Certificate process.	
referenceId	Mandatory	A/N	24	1	The referenceId that is supplied in the associated Transfer Certificate Request (TCR).	
transactionDateTime	Mandatory	Date and Time - offset		1	Date time stamp of the transaction. For example 2016-05-30T09:30:10-06:00	
requestDateTime	Mandatory	Date and Time - offset		1	The TransactionDateTime that is supplied in the associated Transfer Certificate Request (TCR). For example 2016-05-30T09:30:10-06:00	

Segment Name: healthFundResponse

Data Element	Obligation	Format	Size	Repetition	Description	Conditions
Segment	Mandatory			1	One response is required for the TCD.	
responseCode	Mandatory	N	4	1	<p>The response code that indicates the information that the OLD Health Fund is providing to the NEW Health Fund, i.e. whether the TCD is an interim certificate, a complete certificate or the person (s) have been retained, in which case no other information will be supplied.</p> <p>The Valid codes for a TCD are:</p> <p>3000 - Transfer Certificate Details provided</p> <p>3002 - Interim Certificate issued</p> <p>3009 - No cover at Health Fund</p> <p>3010 - TCD for Hospital Only</p> <p>3011 - TCD for General Treatment Only</p> <p>3012 - TCD for Ambulance Only</p>	The response code must be one that is defined in the standardised list of response codes for Transfer Certificate transactions.
responseText	Mandatory	A/N	80	1	The response text to complement the response code as defined by the standardised list of response codes.	

Segment Name: product

Data Element	Obligation	Format	Size	Repetition	Description	Conditions
Segment	Mandatory			1	The product segment contains the production information for the membership.	
coverHistory					Refer to Segment Name: coverHistory	
productDescription					Refer to Segment Name: productDescription	

Segment Name: coverHistory

Data Element	Obligation	Format	Size	Repetition	Description	Conditions
Segment	Mandatory			20	The cover history for the membership	Display cover history for a minimum of 5 years or from join date if member with your Health Fund is less than 5 years.
fromDate	Mandatory	Date	10	1	The commencement date of cover on the product. In the format YYYY-MM-DD, for example 2016-11-19	
toDate	Conditional	Date	10	1	The end date of cover on the product. In the format YYYY-MM-DD, for example 2016-11-19 For an Interim TCD the latest cover history to date is the date the membership is paid up to when the interim response is sent back to the requesting Health Fund.	Must be supplied if the Response Code is: 3000 - Transfer Certificate Details provided; OR 3002 - Interim Certificate issued. It is not required if: The Response Code is 3009 - No cover at Health Fund; OR The Response Code is 3010 - TCD for Hospital Only; OR The Response Code is 3011 - TCD for General Treatment Only; OR The cover is still current at the Health Fund.
productName	Mandatory	A/N	160	1	This is the full name of the product or an indication of whether the cover was suspended or terminated. The options are: Name of the product - The full name of the product. Suspended - If the cover is suspended Terminated - If the cover is terminated	
scale	Conditional	A/N	20	1	This is the scale of the membership from the PREVIOUS (OLD) Health Fund. This is a free text field and the value will be that as supplied by the PREVIOUS (OLD) Health Fund. Refer to Appendix F in the Health Fund Process Flows document for the full list of values that may be received.	Must be supplied if the Product Name is NOT Suspended or Terminated.
productType	Conditional	A/N	31	1	This is the Product Type. Valid values are: Hospital General Treatment Both Ambulance Only General Treatment and Ambulance	Must be supplied if the Product Name is NOT Suspended or Terminated.

Segment Name: productDescription

Data Element	Obligation	Format	Size	Repetition	Description	Conditions
Segment	Conditional			5	The descriptions of the Products the membership had in the last 12 month period. A product description is required for all products within the last 12 months. Descriptions to include; Hospital Excess or product co-payments if any. Exclusions, Benefit limitations, Excess bonuses, loyalty schemes etc.	Must be supplied when the Response Code is: 3000 - Transfer Certificate Details provided; OR 3002 - Interim Certificate issued; OR 3010 - TCD for Hospital Only; OR 3011 - TCD for General Treatment Only. Not supplied when the Response Code is 3009 - No cover at Health Fund
exclusions	Mandatory	Boolean		1	Indication if the product has Exclusions. Valid Values are: True False	
waitingPeriods	Mandatory	Boolean		1	Indication if the product has waiting periods. Valid Values are: True False Health Funds will output the Waiting Period value in the Product Description section of the TCD in one of two ways: 1. An indication of whether the product has waiting periods or not. In most instances the waiting periods value will be True as most Health Fund products have waits. 2. An indication if the membership still has waiting periods to serve on that product. In this case, the values will be: True (waits still to be served) False (all waits are served)	
lifetimeLimits	Mandatory	Boolean		1	Indication whether the product has lifetime limits. Valid Values are: True False	
productName	Mandatory	A/N	160	1	The full Product name	
productDescription	Mandatory	A/N	2000	1	The full Product description. The description should include benefit limitations, excess bonuses, loyalty schemes, unique limits and any additional information that is not supplied elsewhere in the product description fields.	
excessExists	Mandatory	Boolean		1	Indication if the product has an excess. Valid Values are: True False	
coPayExists	Mandatory	Boolean		1	Indication if the product has a CoPay Valid Values are: True False	

sisCode	Optional	A/N	10	1	<p>The SIS or PHIS Code for the product in the format defined by privatehealth.gov.au.</p> <p>The SIS/PHIS Code is a 6-8 character code that consists of the following: State, Unique CMS Code, Type of Cover, Replacement indicator For example, VABC2DR</p> <p>*Note: The full filename for the SIS/PHIS includes the three-character Fund code and the Table code in addition to the SIS/PHIS Code, however for the purpose of product matching only the SIS/PHIS Code is required to be supplied in the TCD.</p>	Minimum length is 1.
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Segment Name: persons

Data Element	Obligation	Format	Size	Repetition	Description	Conditions
Segment	Mandatory			1	The persons segment contains the details for each person that is transferring to the NEW Health Fund.	
person					Refer to Segment Name: person	

Segment Name: person

Data Element	Obligation	Format	Size	Repetition	Description	Conditions
Segment	Mandatory			n	The person segment contains the individual details for a person.	
requestId	Mandatory	N	2	1	The sequence ID of the person, as per the associated TCR Request.	The personRequestId must match that sent in the associated Transfer Certificate Request (TCR) in order to link the person information between the request and response transactions.
relationshipCode	Mandatory	A	20	1	This is the relationship for the person on the membership from the PREVIOUS (OLD) Health Fund. This is a free text field and the value will be that as supplied by the PREVIOUS (OLD) Health Fund. Examples are: Dependant Partner Contributor Refer to Appendix F in the Health Fund Process Flows document for the full list of values that may be received.	
gender	Mandatory	N	1	1	Valid Values are: 1 = Male 2 = Female 3 = Indeterminate 9 = Not Supplied	
givenName	Mandatory	A	40	1	The person's full given name. Put "ONLYNAME" if the person has only one name (no family name)	Minimum length is 2.
secondName	Optional	A	40	1	The person's full second name. Blank if no Second Name	Minimum length is 1.
familyName	Mandatory	A	40	1	The person's full family name OR name if the person only has one name	Minimum length is 2.
dateOfBirth	Mandatory	Date	10	1	The person's date of birth. In the format YYYY-MM-DD, for example 2016-11-19	
joinedDate	Conditional	Date	10	1	The date the person joined the OLD Health Fund. In the format YYYY-MM-DD, for example 2016-11-19	The joinedDate for a person MUST be supplied if they have had one or more days worth of cover.
endDate	Conditional	Date	10	1	The last day of inclusive cover or suspension the person had with the OLD Health Fund. In the format YYYY-MM-DD, for example 2016-11-19 For an Interim TCD the end date is the date the membership is paid up to when the interim response is sent back to the requesting Health Fund.	The endDate for a person MUST be supplied if they have had one or more days worth of cover and the person is terminated on the membership.
rebate					Refer to Segment Name: rebate	
lhc					Refer to Segment Name: lhc	
hospital					Refer to Segment Name: hospital	

generalTreatment					Refer to Segment Name: generalTreatment	
ageBasedDiscount					Refer to Segment Name: ageBasedDiscount	

Segment Name: rebate

Data Element	Obligation	Format	Size	Repetition	Description	Conditions
Segment	Mandatory			1	The rebate segment contains the individual rebate details for a person.	
spe	Mandatory	Boolean		1	Indication if the person has a current Savings Provision Entitlement. Valid Values are: True False	
fundBrandId	Conditional	A	3	1	The three character industry Health Fund code for the OLD Health Fund.	Must be supplied if SPE = True
memberNumber	Conditional	A/N	19	1	The member number of the OLD Health Fund.	Must be supplied if SPE = True
speCode	Conditional	N	2	1	The person's Savings Provision Entitlement rebate level. Valid Values are: 65 = 65 – 69yo 70 = 70yo+	Must be supplied if SPE = True
speFromDate	Conditional	Date	10	1	The original date the SPE commenced from.	Must be supplied if SPE = True

Segment Name: lhc

Data Element	Obligation	Format	Size	Repetition	Description	Conditions
Segment	Conditional			1	The LHC segment contains the individual LHC details for a person.	Supplied if the person has hospital cover AND if person's age > 30
cae	Mandatory	N	2	1	Certified Age of Entry is the age at which the person joined Private Hospital Cover for the first time. Cannot be less than zero	
hospitalEndDate	Mandatory	Date	10	1	The last day the person had Hospital cover. For an Interim TCD where the current cover includes hospital cover, the hospital end date is the date the membership is paid up to.	
paidHospitalDays	Mandatory	N	5	1	How many days of hospital cover the person paid for at a rate that included a loading at the PREVIOUS (OLD) Health Fund(s). If the LHC loading is re-calculated due to non-permitted days without hospital cover then this value resets to zero and the accumulation of the 10 year period starts again from the date the recalculated loading was applied. If the LHC percentage loading gets reset to zero then there is no need to accumulate paid hospital cover hence this field should be left as zero filled. Note: Periods of suspension or day of absence do not count towards paid days of hospital cover days counted are only required once a LHC loading % is greater than 0% A Person's Paid Hospital Days must be greater than or equal to 0.	

lhcOverride	Mandatory	Boolean		1	<p>Denotes whether a person's LHC loading rate has been overridden. This occurs when that person has had 10 years' worth of hospital cover at a rate that includes a loading.</p> <p>Valid Values are: True (LHC has been overridden) False (LHC not overridden)</p> <p>Note: If true, then any Entry Age or Absence Days are ignored. A LHC % loading must cease to be applied on the day of the last day of the Ten year period of continuous complying hospital treatment cover (PHI Act Chapter 2, Division 34-10). The default setting is "False". This field shall change to "True" if the LHC loading is > 0% and the accumulated number of paid hospital days since a LHC Loading was applied = 3652 days. Note when this field is set to "True" it overrides the normal LHC calculation process by setting the LHC percentage to zero. This field will be changed from "True" to "False" (where the normal LHC calculations are re-applied) when the LHC recipient has 1 day of absence after the 10 year reset and that person has used or exceeded their permitted days of absence i.e. has total absent days over 1094.</p>	
loadingPercentage	Mandatory	N	3	1	<p>The Loading Percentage is the additional % being charged due to LHC. Note where a person has a CAE of 30 and absent days = 1295 (> than 1094) then this would be displayed as CAE = 30, absent days = 1295, % loading = 2. The % loading is only used as a reference it should not be input into the receiving Health Fund's system. The receiving Health Fund's system should calculate the % from the CAE, absent days, Hospital End Date and LHC % override.</p>	
totalAbsentDays	Mandatory	N	5	1	<p>Total Absent Days is the number of days without hospital cover since they received their initial CAE. The absent days submitted should only be calculated up to the Hospital End Date NOT the cease date if hospital cover did not equal the cease date.</p> <p>NOTE: it is the NEW Health Funds responsibility to calculate the absent days from the day of last hospital cover. If there is a gap between the Hospital End Date and the date the person joined the New Fund, then it is expected the New Fund's system automatically calculates the new total absent days.</p>	

Segment Name: hospital

Data Element	Obligation	Format	Size	Repetition	Description	Conditions
Segment	Conditional			1	The Hospital segment contains the last period of hospitalisation for a person and/or the date the hospital wait exemption was used.	Supplied if the person has had a period of hospitalisation OR if they have used the hospital waiting period exemption.
fromDate	Conditional	Date	10	1	The admission date for the hospitalisation. This is for the LAST period of hospitalisation for the person.	Must be supplied when there has been a period of hospitalisation.
toDate	Conditional	Date	10	1	The discharge date for the hospitalisation. This is for the LAST period of hospitalisation for the person.	Must be supplied when there has been a period of hospitalisation.
waitExemption	Conditional	Date	10	1	The date that the person used the hospital wait exemption i.e. where an override of the cover upgrade standard waiting periods was used in accordance with the Mental Health Reform 2018.	Must be supplied when the person has used the exemption.

Segment Name: generalTreatment

Data Element	Obligation	Format	Size	Repetition	Description	Conditions
Segment	Conditional			1	The general treatment segment contains details of benefits paid for specific modalities for a person.	Must be supplied if Product Type = General Treatment; General Treatment and Ambulance; or Both AND a benefit has been paid in the limit year for one or more of the Modalities Not required for Ambulance Only
modality					Refer to Segment Name: modality	

Segment Name: modality

Data Element	Obligation	Format	Size	Repetition	Description	Conditions
Segment	Conditional			n	The modality segment contains the benefit details per modality for a person. The benefits assigned to a specific modality are based on the OLD Health Fund's modality definitions.	Supplied if the person has had benefits paid for a modality in one or more of the following periods: Previous 6 months; Current 6 months or Lifetime
name	Mandatory	A	30	1	The general treatment modality that the person has benefits for. Valid Values are: Acupuncture Artificial Aids Chiropractic and Osteopathy Major Dental General Dental Dietetics Health Management Hearing Aids Natural Therapies Occupational Therapy Optical Orthodontic Pharmacy Physiotherapy Podiatry Psychology Remedial Massage Speech Therapy	Mandatory for the modality element. Health Management includes (but is not limited to) the following: Weight loss programs, quit smoking programs, gym programs, bowel screening kits, health screening, health checks, nicotine replacement, yoga, pilates, swimming, mole scanning, health risk assessment, disease management membership fees, asthma management, cancer management, group therapies, injury prevention, mental health, pregnancy and childbirth, preventative health services, vaccinations, bone density scans, personal health coaching, health screening checks, exercise physiology, stress management, artificial aids and appliances, first aid programs and equipment hire/purchase.
benefits					Refer to Segment Name: benefits	

Segment Name: benefits

Data Element	Obligation	Format	Size	Repetition	Description	Conditions
Segment	Mandatory			3	The benefits segment contains the benefit details paid for the modality within a given period for the person.	
period	Mandatory	A	20	1	The period that the benefit was paid in for the specific modality. Valid Values are: Previous 6 months Current 6 months Lifetime	Only output the period if the benefit amount for the period is greater than zero.
amount	Mandatory	N	9	1	The benefit amount (in whole dollars, for example \$40 is sent as 40) that have been claimed within the limit year i.e. financial or membership year. For the Orthodontic modality this is the benefit amount claimed in 5 years.	

Segment Name: ageBasedDiscount

Data Element	Obligation	Format	Size	Repetition	Description	Conditions
Segment	Conditional			1	The age-based Discount segment contains the individual discount details for a person.	Supplied If the person has had hospital cover and the person is considered to be an adult.
certifiedDiscountAge	Conditional	N	2	1	Certified Discount Age is the person's age at the 'Discount Assessment Date' as defined in the Private Health Insurance (Complying Product) Rules 2015. The values in this field are within the range 18-29, inclusive.	Must be supplied if the person is on an age-based discount product and the person has a certified discount age.
agePercentage	Mandatory	N	3	1	The Age Percentage is the discount % being applied due to age-based discount. Zero if no age-based discount applies	
hospitalEndDate	Mandatory	Date	10	1	The last day the person had Hospital cover. For an Interim TCD where the current cover includes hospital cover, the hospital end date is the date the membership is paid up to.	