

---

GOVERNMENT NOTICES • GOEWERMENTSKENNISGEWINGS

---

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-authorization 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
	<b>Exceptions:</b>	
	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**

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

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

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

**FORM 7 PROSTHETIC / ORTHOTIC DEVICE QUOTATION:**

Employee: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Diagnosis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<u>Code</u>	<u>Description</u>	<u>Amount excl VAT.</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____	_____	_____
_____	_____	_____

Remarks:

Treating Medical Service

Service Provider Signature:

Print name:

Date:

Employee Signature:

Print name:

Date:

**DIAGNOSIS SPECIFIC FORMS**

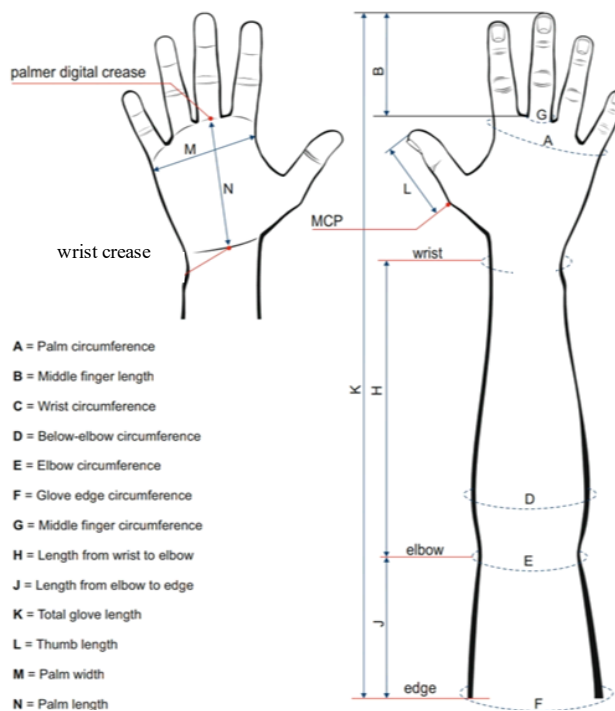
**Partial Hand Prosthesis**

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**

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





Highlight / colour in amputated site.

<b>Occupational therapist rehabilitation proposal and quotation included for primary amputee?</b>	<b>YES</b>	<b>NO</b>
<b>Comment:</b>		

**Comments:**

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

**Prosthetist Signature:**

**Employee Signature:**

**Print name:**

**Print name:**

**Date:**

**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**

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

**Comments:**


---



---



---

---

---

---

---

---

---

---

---

---

---

**Prosthetist Signature:**

**Employee Signature:**

**Print name:**

**Print name:**

**Date:**

**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**

<b>Amputation side</b>		<b>Left / Right</b>			
<b>Dominant hand</b>		<b>Left / Right</b>			
<b>Pictures included? (Mandatory)</b>		<b>Yes / No</b>			
<b>Comments:</b>					
<b>Measurements</b>					
<b>Sound side</b>			<b>Residual limb</b>		
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)		
<b>Residual drawing:</b>			1		mm
			2		mm
			3		mm
			4		mm
			5		mm
			Limitation in Shoulder ROM?	Yes	
Skin graph	Y/N	Bony prominences	Y/N	Scar tissue	Y/N
<b>Date of last prosthetic issue</b>					
<b>Which Prosthetist issued patient’s previous prosthesis?</b>					
<b>Desired activities employee wants to achieve with the prescribed prosthesis</b>					

**Comments:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

---

---

---

---

---

---

**Prosthetist Signature:**

**Employee Signature:**

**Print name:**

**Print name:**

**Date:**

**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**

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

**Comments:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

---

**Prosthetist Signature:**

**Print name:**

**Date:**

**Employee Signature:**

**Print name:**

**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			
	<b>Fixed</b>		<b>Correctable</b>
	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:

Print name:

Date:

Employee Signature:

Print name:

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	<b>Fixed</b>		<b>Correctable</b>			
Comments	Scoliosis		Kyphosis			
	Lordosis		Gibbous			
	Anterior pelvic tilt		Posterior pelvic tilt			
	Pelvic rotation		Pelvic obliquity			
	Joint contractures		Hip dislocation			
Skin integrity						
Pain						
<b>Other comments:</b>						
Pictures included? (Compulsory)				Y / N		
ENVIRONMENTAL ASSESSMENT						
Residential area	Rural		Informal		Suburban	
Terrain accessed mostly	Even		Sloppy		Rocky	Sandy
Toilet accessibility	Yes				No	

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

**Comments:**

---



---



---



---



---



---



---



---



---



---



---

---

---

---

---

---

---

**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

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

Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

---

---

---

**Prosthetist Signature:**

**Employee Signature:**

**Print name:**

**Print name:**

**Date:**

**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				
Weight of employee	kg	Comment:				
Pictures included? (Mandatory)	Yes / No					
<b>Measurements</b>						
<b>Sound side</b>			<b>Residual limb</b>			
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:





**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		
Weight of employee		kg	Comment:		
Pictures included? (Mandatory)		Yes / No			
<b>Measurements</b>					
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:**

**Employee Signature:**

**Print name:**

**Print name:**

**Date:**

**Date:**

**PARTIAL FOOT / ORTHOPAEDIC SHOE**

Employee name and surname: \_\_\_\_\_

Claim number: \_\_\_\_\_

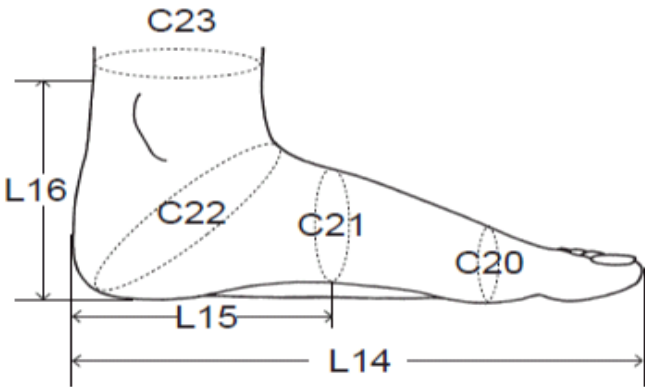
\*Filled and signed AMPPRO / AMPnoPRO sheet mandatory with submission (Prosthetics only)

\*\* 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	
Weight of employee		kg		Comment:	
Pictures included? (Mandatory)		Yes / No			
<b>Measurements</b>					
					
<b>Sound side</b>			<b>Residual / Effected limb</b>		
Circumference C20		mm		Circumference C20	
Circumference C21		mm		Circumference C21	
Circumference C22		mm		Circumference C22	
Circumference C23		mm		Circumference C23	
Length L14		mm		Length L14	
Length L15		mm		Length L15	
Length L16		mm		Length L16	
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 /					





**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

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

# PRIVATE HOSPITAL

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