Patient Registration User Map

PAGE ONE

1. **Eligibility Status**
   I Ineligible
   D Direct Only
   C CHS & Direct
   P Pending

2. **Date of Birth**
   Format: 010101

3. **Place of Birth [City]**
   2-20 characters

4. **ST (Place of Birth)**
   Two-digit abbreviation

5. **Sex**
   M Male
   F Female

6. **Social Security Number**
   Nine digits

7. **Marital Status**
   Choose from list

8. **Current Community**
   Select Date Moved
   Format: 010101
   Community of Residence
   Town or community name

9. **Street Address [Line 1]**
   3-35 characters

10. **Street Address [Line 2]**
    3-30 characters

11. **Street Address [Line 3]**
    3-30 characters

12. **City**
    2-15 characters

13. **ST**
    Two-digit abbreviation

14. **Zip Code**
    Five numeric digits

15. **Location of Home**
    Free text field

16. **Phone Number [Residence]**
    4-20 characters

17. **Work Phone**
    5051234567

18. **Other Phone**
    5051234567 (C)
    5051234567 (M)

PAGE TWO

1. **Religious Preference**
   Choose from list

2. **Classification/Beneficiary**
   Choose from list

3. **Tribe of Membership**
   Choose from list

4. **Tribe Quantum**
   Enter fraction of Tribe in which enrolled. Enter F if full.

5. **Indian Blood Quantum**
   Enter fraction of Indian blood. Enter F if full. Must be equal to combined Tribe quantum(s).

6. **Tribal Enrollment No.**
   1-12 characters
   Obtain from Tribe letter or CDIB.

7. **Other Tribe**
   Choose from list if patient claims more than one Tribe.

8. **Father's Name**
   Last,First Middle
   Father's city of birth
   3-15 characters
   Father's state of birth two-digit abbreviation

9. **Father's Cell Phone**
   5054508212

10. **Father's email address**
    Free Text

11. **Father's Alternate Phone Number**

12. **Mother's Maiden Name**
    Last,First Middle
    Mother's city of birth
    3-15 characters
    Mother's state of birth; two-digit abbreviation

13. **Mother's Cell Phone Number**

14. **Mother's email address**

15. **Mother's Alternate Phone Number**

16. **Employer Name**
    3-25 characters
    Employment Status
    1 Full-time
    2 Part-time
    3 Unemployed
    4 Self employed
    5 Retired
    6 Active military duty
    9 Unknown

17. **Spouse's Employer Name**
    3-25 characters

18. **Father's Employer Name**
    Type employer name if patient is under 18 years old.

19. **Mother's Employer Name**
    Type employer name if patient is under 18 years old.

PAGE THREE

1. **E-Name**
   Emergency contact name. Last,First Middle

2. E-Phone Number

Emergency contact's phone number.

5051234567

3. EC Relationship

Choose from list.

Spouse is 02 and parent is 18.

4. E-Street Address

Emergency contact's address. If it is the same as the patient, type SAME and 4-7 will auto populate.

5. E-City

Emergency contact's city.

3-30 characters

6. E-State

Emergency contact's two letter state abbreviation

7. E-Zip Code

Emergency contact's five-digit zip code

8. K-Name of Primary NOK

Name of Next of Kin. Should be different than emergency. Last,First Middle

9. K-Phone Number

NOK phone number.

505 123 4567

10. NOK Relationship

Choose from list.

Spouse is 02 and parent is 18.

11. K-Street Address

NOK's address.

12. K-City

NOK's city.

3-30 characters

13. K-State

NOK's two letter state abbreviation

14. K-Zip Code

NOK's five-digit zip code.

PAGE FOUR

A(dd) an Insurer

Select Insurer Name

Choose from list

Private Insurance

1. Policy Holder

Last,First Middle

Enter SAME if the patient is the policy holder.

Holder's Address- Street

Policy holder's address.

3-30 characters

Holder's Address- City

Policy holder's city.

3-20 characters

Holder's Address- State

Policy holder's state.

Emergency's two letter state abbreviation

Holder's Address- Zip

Policy holder's zip code.

five-digit zip code

Holder's Telephone Number

Policy holder's telephone number

505 123 4567

2. Policy or Social Security Number

3-20 characters

3. Effective Date

Date insurance active

010101

4. Expire Date

Date insurance ends

If not noted on card leave blank

010101

5. Policy Holder's Gender

M Male

F Female

6. Policy Holder's Date of Birth

Policy holder's date of birth

010101

7. Primary Care Provider

Last,First Middle

Usually required for HMO/ Managed Care Plans

Member Number

Found on the card

1-20 characters

8. Card Name

Last,First Middle

Enter policy holder's name exactly as it appears on the card

9. Holder's Employment Status

1 Full-time

2 Part-time

3 Unemployed

4 Self employed

5 Retired

6 Active military duty

9 Unknown

10. Employer

Choose from list

Enter Employer Demographics

11. Select Group Name

Choose from list

Usually employer name

Select Group Number

The group number auto populates based on the Group Name

12. Select Coverage Type

Choose from list

Person Code

2-20 characters

13. Card Copy on File

Y Yes

N No

Date CC was Obtained

010101

14. - … Policy Members

Enter policy member's name, person code, member number, HRN, relationship to primary card holder, and eligibility start and end dates.

Medicare

1. Med. Release Date

010101

2. QMB/SLMB

Q QMB

S SLMB

U Unknown

P Pending

N None

3. Imp Msg Form MCR Sig Obtained

010101

4. Advance Beneficiary Notice

010101

5. Medicare Name

Last,First Middle

Enter the name exactly as it appears on the card.

6. Medicare Number

Enter nine-digit number on card

Suffix

One to two-digit suffix following the nine-digit number on the card

7. Primary Care Provider

Last,First Middle

8. Date of Birth

010101

Enter the date of birth exactly as defined by Medicare

9. Card Copy on File

Y Yes

N No

Date Medicare CC was Obtained

010101

10. -…Coverage List

Enter the Eligibility Date Begin, Date Updated, Coverage Type, Plan Name, and Eligibility End Date

Medicaid

1. Medicaid Number

6-30 characters

2. Eligibility Date

010101

Eligibility End Date

010101

Coverage Type

1-2 characters

Varies by state (18 self in NM)

3. Medicaid Name

Last,First Middle

Enter the name exactly as it appears on the card.

4. Medicaid Date of Birth

010101

Enter the date of birth exactly as defined by Medicaid.

5. Primary Care Provider

Last,First Middle

6. Group Name

Choose from list Usually employer name

Select Group Number

The group number will auto populate based on the Group Name

7. Plan Name

Choose from list

New Mexico Medicaid

8. Rate Code

One- to six-digits

Varies by state 15

9. Medicaid Card Copy on File

Y Yes

N No

Date Medicaid CC was Obtained

010101

PAGE FIVE

This is a summary page showing all Benefit Coordination cases and preauthorizations.

Case Information

Case Date

010101

Assigned To

Last,First Middle

Assigned By

Last,First Middle

Reason

1-45 characters

Reason case was assigned

Prior Authorization Information

Prior Authorization Number

1-45 characters

Encounter Date
010101

Admission Date
010101

Insurer
Insurance Name

Type
IP Inpatient
OP Outpatient
DS Day Surgery
CHS Contract Health Services
D Dental

Add <C>ase

1. **Case Date**
010101
   By
   IHS employee assigning/
   referring the case

2. **Case Number**
6-30 characters
Facility specific

3. **Case Type**
IP Inpatient
OP Outpatient
DS Day Surgery
CHS Contract Health Services
D Dental

4. **Case Worker**
Last,First Middle

5. **Case Reason**
1-45 characters
Reason for the case

6. **Completed By**
Last,First Middle

7. **Assigned to**
Last,First Middle

8. **Notes**
   Date Application Obtained
   010101

   Application Type
   (Vary by facility)
   Medicaid Application
   Medicare Part A
   Medicare Part B
   Medicare Part D
   Social Security Application

   Overall Status of Application
   P Pending
   A Approved
   D Denied
   R Re-Submitted
   F Follow Up Needed
   E Entered in Error

   Person Receiving Application
   Last,First Middle
   Spend Down Information

   Date Referred
   010101

   Date Expense Requested
   Date of medical treatment
   010101

   Action Taken
   Note any action taken in
   relation to the Spend Down
   3-30 characters

   Spend Down
   The dollar amount that the
   patient must spend before they
   qualify for Medicaid.

PAGE SIX

1. **Veteran (Y/N)**
Y Yes
N No

2. **Service Branch [Last]**
Choose from list

3. **Service Entry Date [Last]**
010101
Found on the VA card.

4. **Service Separation Date [Last]**
010101
Found on the VA card.

5. **Vietnam Service Indicated?**
Y Yes
N No
U Unknown

6. **Service Connected**
Y Yes
N No

7. **Claim Number**
7-8 numeric characters found
on the VA card OR enter SS if
it is the same as the patient's
Social Security number.

8. **Description of VA Disability**
3-60 characters

9. **Valid VA Card**
Y Yes
N No
   If No, Informed how to obtain a VA card
   Y Yes
   N No

PAGE SEVEN

1. **Date of Death**
Patient's date of death.
01/01/08@10AM

2. **State of Death**
Two letter state abbreviation

3. **Death Certificate No.**
6-8 characters

4. **Edit Other Names**

Enter a new alias.

Last,First Middle

5. **Edit Legal Names**

Do you wish to (E)dit or (A)dd a new proof of name change?

A Add

E Edit

If Adding, Patient Name Changes Patient Name To:

Last,First Middle

Patient Name Changes Proof Provided

Choose from list

Patient Name Changes Document Number

3-20 characters

If Editing, Select Patient Name Changes Date Changed

010101

Patient's Name Changed To

Last,First Middle

Proof Provided

Choose from list

Document Number

3-20 characters

PAGE EIGHT

Do You Wish to Edit Additional Patient Registration Information?

Y Yes

N No

If yes, Edit?

Y Yes

N No

If yes, there is a free text field. Enter in format: Date,

Additional Information, IHS employee Initials.

To exit, F1-E to exit the field and save the information.

PAGE NINE

1. **Reason for eligibility status**

Do you wish to (E)dit or (A)dd an eligibility modifier?

E

A

If E, Select eligibility modifiers

Choose an existing modifier.

After // choose new modifier.

Type @ to delete entry.

If A, Select eligibility modifiers

Choose from list

2. **Status of Medical Record**

Record disposition

Inactive Record (On file here)

New Chart

No Active Chart

Reactivated

Registered in Error

Sent to Archives

NOTE: If patient has been to the facility within the past 3 years, leave this field blank.

3. **Other Legal Documents**

Do you wish to (E)dit or (A)dd a new legal doc?

E

A

If E, Select patient's legal docs date/time of entry

Date of entry 010101

Legal document

To delete the document type @.

To edit the document information, enter the new information (document type, date, etc.) after //

If A, Patient's legal docs legal document

Choose from list

Patient's legal docs date added to file

Date of entry 010101

Patient's legal docs document number

3-20 characters when applicable

Patient's legal docs effective date

010101 when applicable

4. **Advance Directives**

Select date of entry

Date of entry 010101

Advance directive

Yes

No

If Yes, Type

Living Will

Power of Attorney

If No, Reason

Enter reason patient did not provide advance directives.

3-30 characters

5. **Rel of Information**

010101

6. **Assignment of Benefits**

010101

7. **Notice of Privacy Practices (NPP) Received by Patient**

8. **Acknowledgement of Receipt of NPP Signed**
   Yes
   No
   If No, Reason
   3-80 characters

9. **Restricted Health Information**
   Leave blank if none, otherwise:
   3-80 characters
   Status Code
   A Approved
   E Entered in Error
   Status Date
   010101
   Approving Official Status Date
   010101
   Approving Official
   3-20 characters

PAGE TEN

1. **Ethnicity**
   Declined to answer
   Hispanic or Latino
   Not Hispanic or Latino
   Unknown by Patient
   Method of Collection
   Observer
   Proxy
   Self Identification
   Unknown

2. **Race**
   American Indian or Alaska Native
   Black or African American
   Declined to Answer
   Native Hawaiian or Pacific Islander
   Unknown by Patient
   White

3. **Primary Language Spoken at Home**
   If English is chosen
   How proficient is the patient in Speaking English?
   Very Well
   Well
   Not Well
   Not at All
   Primary language if other than English
   Interpreter Required?
   Yes
   No
   Unknown

4. **Indicate Preferred Language**
   Enter Name of Language or ? for a list of languages.

5. **Migrant Worker?**
   Y – Yes
   N – No
   If Yes, Type:
   M – Migrant Agricultural Worker
   S – Seasonal Agricultural Worker

6. **Homeless**
   Yes
   No

If Yes, Type:
Homeless Shelter
Transitional
Doubling Up
Street
Other
Unknown

7. **Internet Access?**
   Yes
   No
   If Yes, Access Web from:
   Home
   Work
   School
   Healthcare Facility
   Library
   Tribal/Community Center

8. **Patient's email address**

9. **Generic Health Permission**
   Yes or No

10. **Preferred Method of Receiving Reminders:**
    P Phone
    E Email
    M Mail

11. **Number in Household**
    Number between 0-99

12. **Total Household Income**
    Type number between 0-999999
    House Income Period
    Year
    Monthly
    Weekly
    Biweekly

Explanation of Fields

PAGE ONE

1. **Eligibility Status**: The patient's eligibility to receive care at the IHS facility. Ineligible status is a person who is not eligible to receive care unless they are in an urgent situation OR pay for the service at the time of service.

   Direct Only status is a person of Indian descent who belongs to the local community or a non-Indian women pregnant with an eligible Indian's child. Other special situations requiring care include disease control and emergency care.

   CHS & Direct status is a person who is an enrolled member and resides on or near a reservation established for the tribe OR maintains close economic and social ties with that Tribe. He/she qualifies for contract health services as well as direct care.

   Pending status is a person who is eligible pending verification of information (I.e., CDIB, Tribe letter, birth certificate, etc.).

15. **Location of Home**: This field allows you to enter directions to a home when the address of the patient on file is a P.O. Box.

PAGE TWO

2. **Classification/Beneficiary**: The primary classification under which the patient qualifies for IHS care. Until the present law is amended, patients are usually qualified because they possess Indian blood. Common selections are 01 Indian/Alaska Native and 03 Commissioned Officer.

5. **Indian Blood Quantum**: The actual blood quantum fraction of the patient must be entered into the Patient Registration System as verified with BIA documents. Since membership in a Tribe is important for Contract Health eligibility, a notation regarding verified blood quantum should made in the Patient Registration System. Indian Blood Calculator.

PAGE FOUR

Adding Private Insurance:

12. **Person Code**: The person code signifies the relationship between the primary insurance carrier and insured. Usually 18 signifies "self", however, it depends on the state.

Adding Medicare:

1. **Med. Release Date**: The date that the patient authorizes the release of information for Medicare billing. This form should be obtained at each visit.

2. **QMB/SLMB**: The QMB and SMLB help Medicare beneficiaries of modest means pay all or some of Medicare's cost sharing amounts (i.e., premiums, deductibles, and co-payments). Briefly, the QMB program pays Part A premiums, Part B premiums, co-insurance and deductibles for Medicare Parts A and B. Participants must be at or below 100% of the annual poverty level. The SMLB program pays the Part B monthly premium. Participants must be between 100% and 120% if the annual federal poverty level.

3. **Important Message from Medicare Signature Obtained**: The date that the Medicare patient signs the Important Message from Medicare form. This signature should be obtained the first time that Medicare is reported.

4. **Advance Beneficiary Notice**: The date that the patient signs the ABN. A signature should be obtained at each visit.

PAGE FIVE

    Spend Down Information: Some patients automatically qualify for Medicaid. Some seniors and people with disabilities whose incomes exceed the income limit, however, may qualify for Medicaid if they have medical bills that are equal to OR greater than their "excess" income. These patients qualify for Medicaid if within a six-month period they incur medical expenses in an amount that equals or exceeds the Medicaid limit. When that occurs they will receive full Medicaid coverage -- until the end of the six-month spend down period.

PAGE NINE

1. **Reason for Eligibility**: This field allows you to add modifiers to the patient's eligibility status. The list of available modifiers will depend on the patient's status, and may be viewed by typing ?? at the "Reasons for [eligibility status]:" prompt. During entry, an eligibility status is assigned. The eligibility status appears on Page 9 where a modified may be added or edited.

2. **Status of Medical Record**: This field contains a short description of patient's medical record status. You can view a list of available options by typing ?? at the prompt. If a patient has attended the facility within the past three years, this field will remain blank. The HIM (Health Information Management) Dept uses this field when a patient does not attend the facility for three years. After three years, the medical record is sent to archives. When this process is completed, the local users should input the status of this record in the Patient Registration application instructing future users on the whereabouts of the record. If the patient returns to the facility, a request may be made to retrieve the original record from the archives.

3. **Other Legal Documents**: This field allows your site to track another form of paper proof provided by the patient. The reason for tracking other legal documents is at the site's direction. You can add/edit in this field.

4. **Advance Directives**: The patient's wishes in the event of a life-threatening situation. If Advance Directives are noted, the Patient Registration application prompts the user to indicate whether the Advance Directives are in the form of a living will or power of attorney. If it is noted that Advance Directives have not been obtained, the Patient Registration application will prompt the user to note the reason they were not obtained.

5. **Release of Information**: This field allows the site to track the date that the patient signed the Release of Information form. The Release of Information allows IHS to disclose all or any reasonable part of the patient's record for billing purposes. This authorization should be signed the first time that the patient attends the facility and remains in effect indefinitely unless it is revoked in writing.

6. **Assignment of Benefits**: This field allows the site to track the date that the patient signed the Assignment of Benefits form. This is authorization given by the patient to the facility allowing the facility to directly receive the health benefits payments. The provider, for example, accepts payment from Medicare as payment in full. If a provider accepts assignment from a non-beneficiary, the deductible and coinsurance can be billed to the patient. This form must be signed annually.

7. **Notice of Privacy Practices** (NPP): This field allows the site to track the date that the patient was given the Notice of Privacy Practices. This NPP is IHS's statement explaining the ways in which IHS adheres to HIPAA regulations. The NPP describes the ways in which the patient's medical information may be used and disclosed by the facility. The NPP field auto populates based on information entered when a new patient is added. This date is required the first time that the patient attends the facility.

8. **Acknowledgement of Receipt of NPP Signed**: This form must be signed once over the patient's lifetime. This field allows the site to track the date that the patient signed his/her Acknowledgement of Receipt of the

NPP. This is a mandatory field and HIPAA required. If the user notes that the NPP was ***not*** signed, he/she is prompted to enter the reason the form was not signed.

9. **Restricted Health Information**: Indicates patient's records that are flagged as containing Restricted Health Information (RHI). When adding a patient, this question is asked and the information is auto populated into the Page 9 summary screen.

PAGE TEN

1. **Migrant Worker Status**: migrant workers are classified as being one of two types.

   A migrant agricultural worker is defined as an individual whose principal employment is in agriculture on a seasonal basis, as opposed to year-round employment, and who establishes a temporary home for the purposes of such employment.

   A seasonal agricultural worker is defined as an individual whose principal employment is in agriculture on a seasonal basis and who does not establish a temporary home for the purpose of employment.

2. **Homeless Status**

   Transitional. Once a homeless person obtains housing, he or she is often considered to be in a transitional status for a considerable period of time.

   Doubling Up. Refers to situation where an individual is unable to maintain their housing situation and is forced to stay with a series of friends and/or extended family members.

   Street. Includes living outdoors, in a car, in an encampment, in makeshift housing/shelter, or in other places not deemed safe or fit for human occupancy.