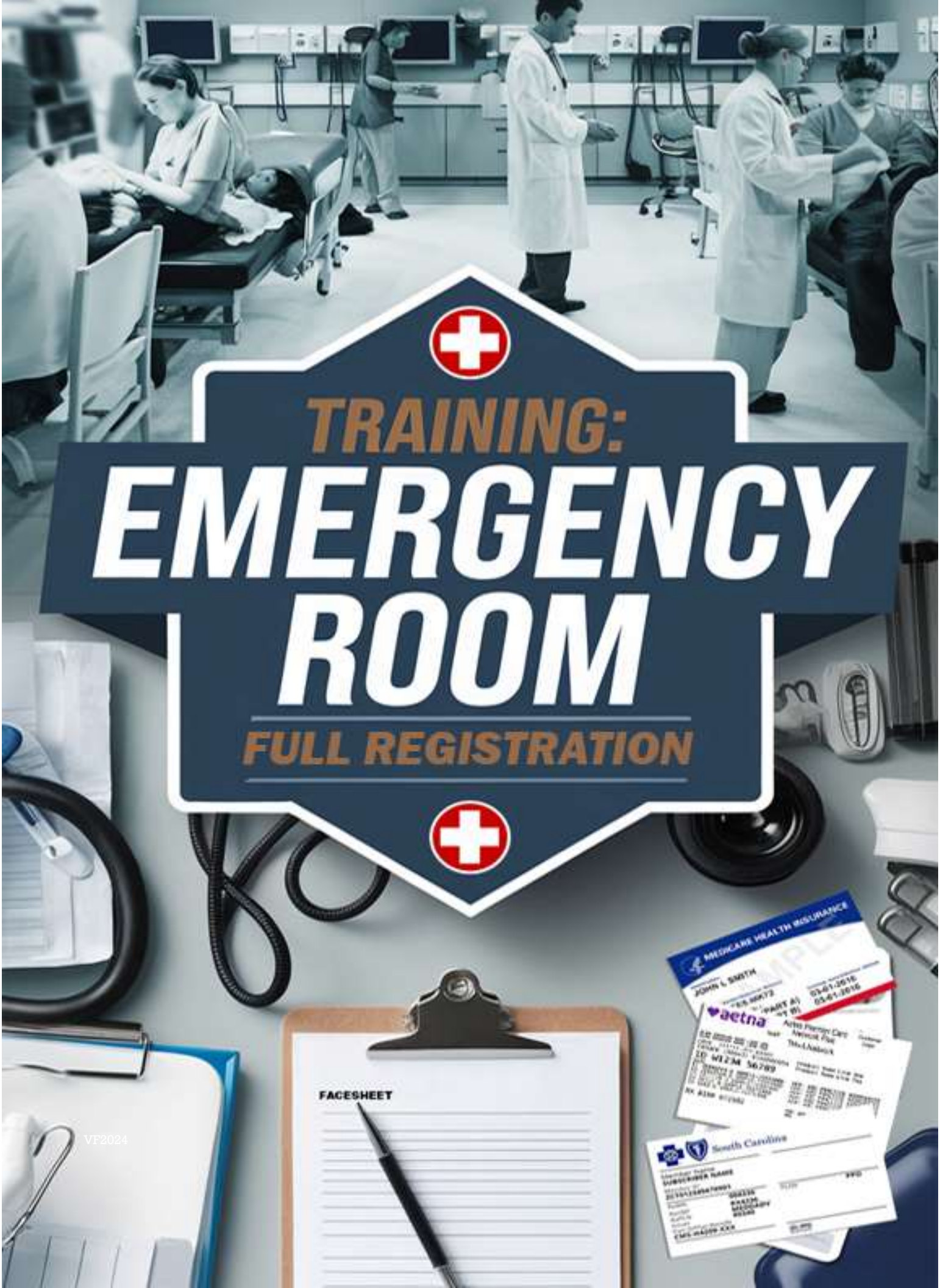
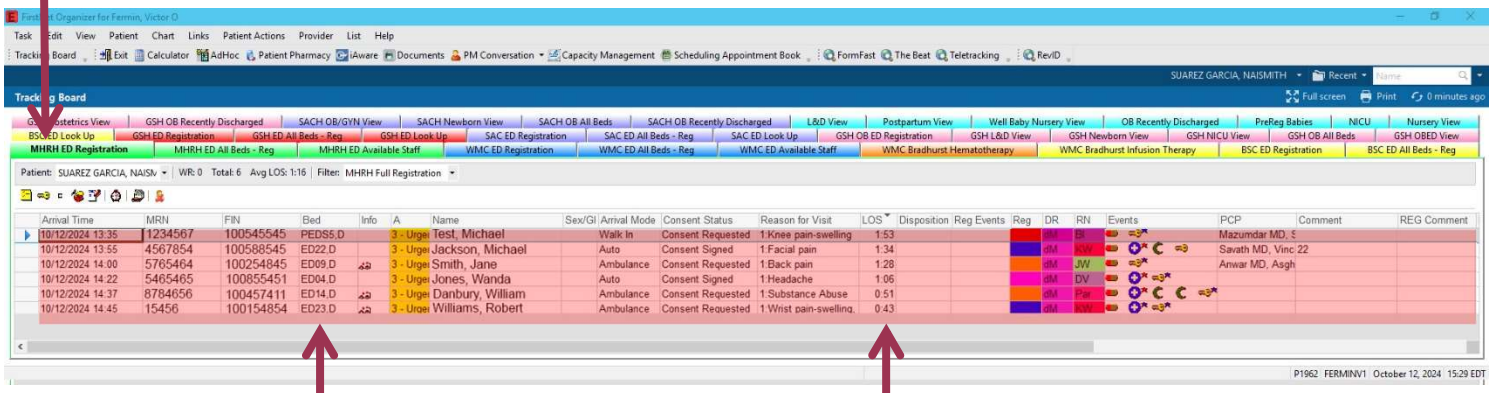

TRAINING:
EMERGENCY ROOM
FULL REGISTRATION
FACESHEET
MEDICARE HEALTH INSURANCE
aetna
South Carolina
VF2024

Tracker / Worklist Tab

Registration Worklist:

- All patients who are ready to be updated will listed on the tab MHRH ED Registration.

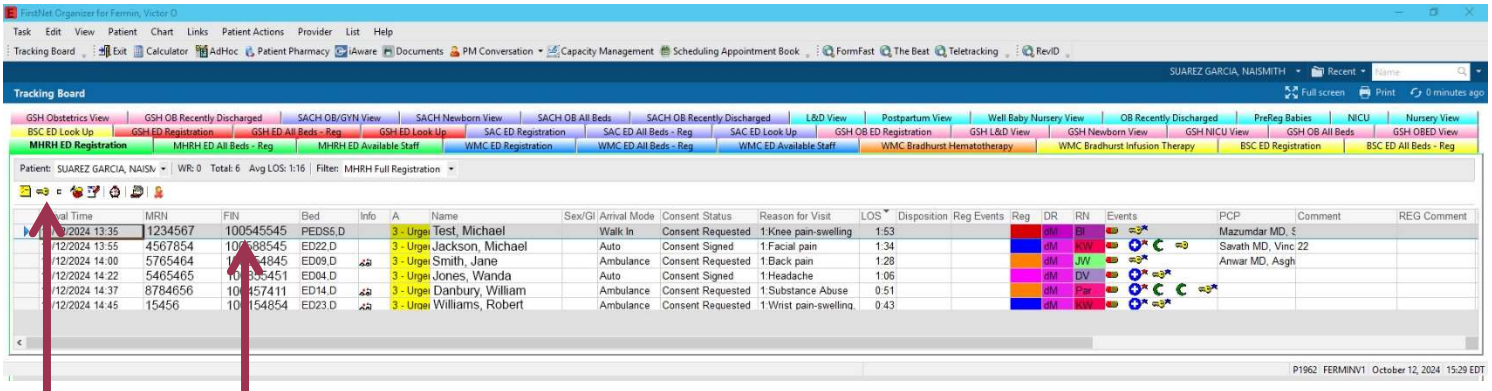


Patient's Location:

- The patient's location is listed next to the patient's name

Length of Stay:

- The patients are sorted by length of stay

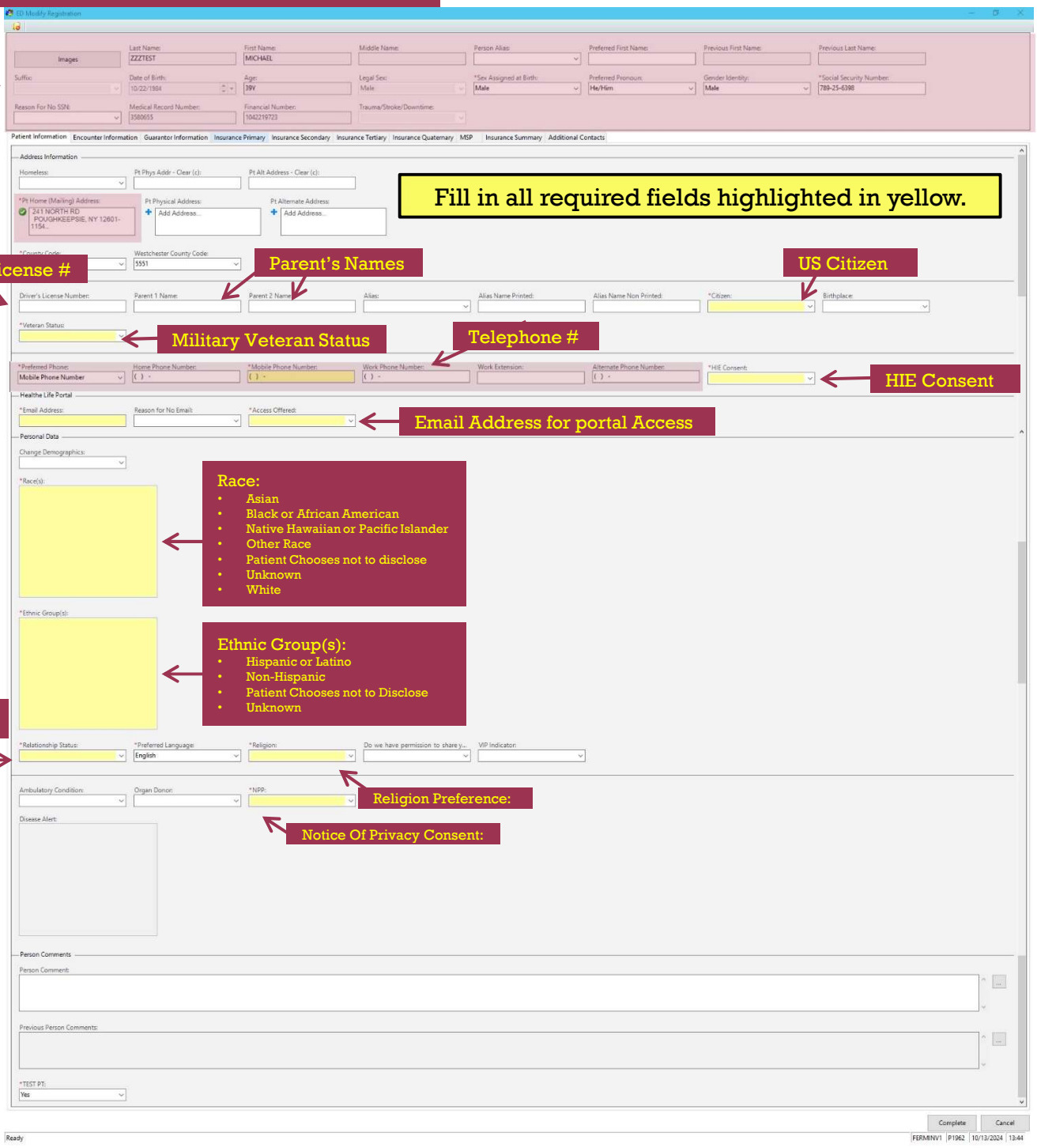


Updating Registration:

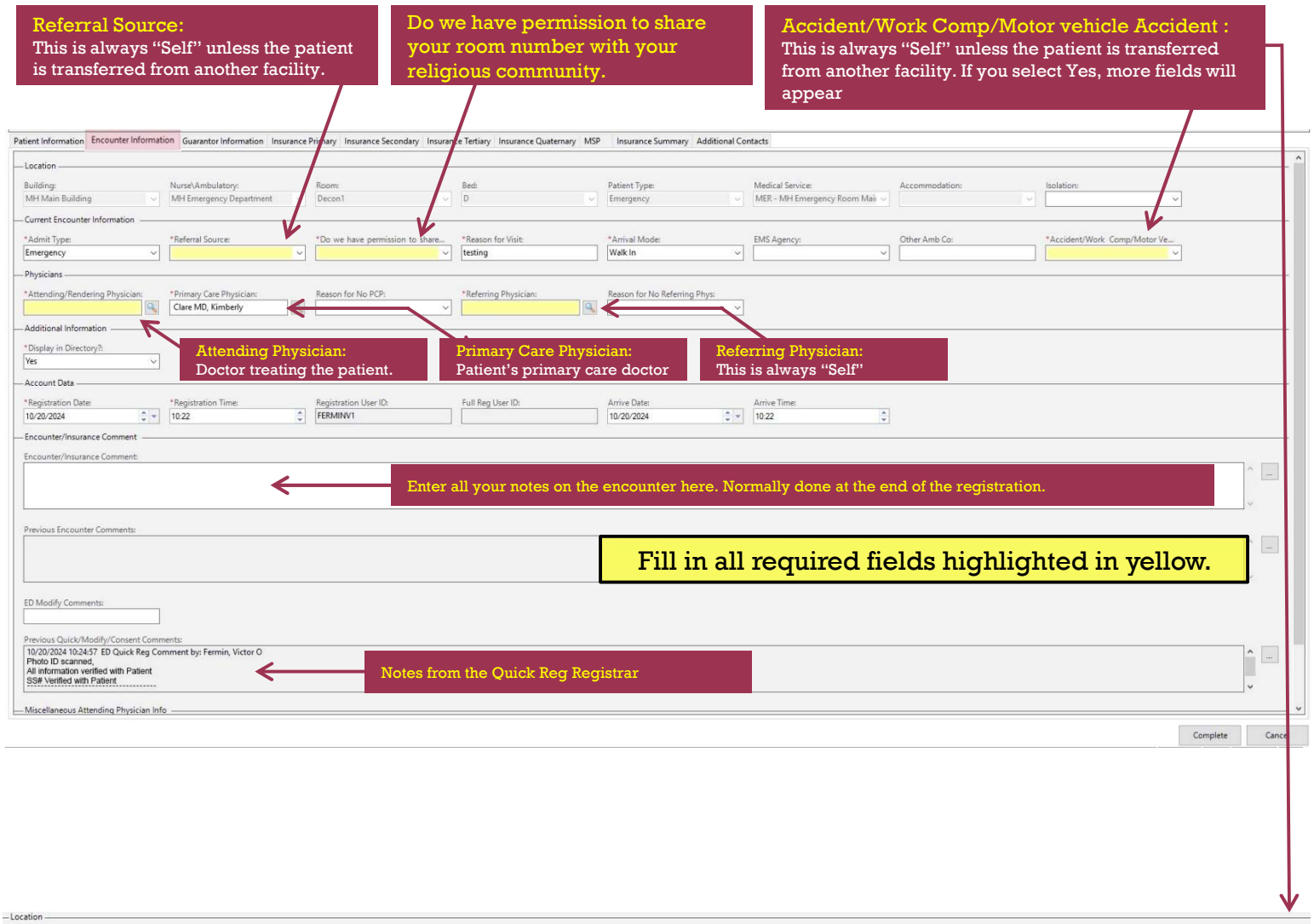
- Highlight the patient you are going to update.
- Click on the ED Full Registration (Yellow Key)

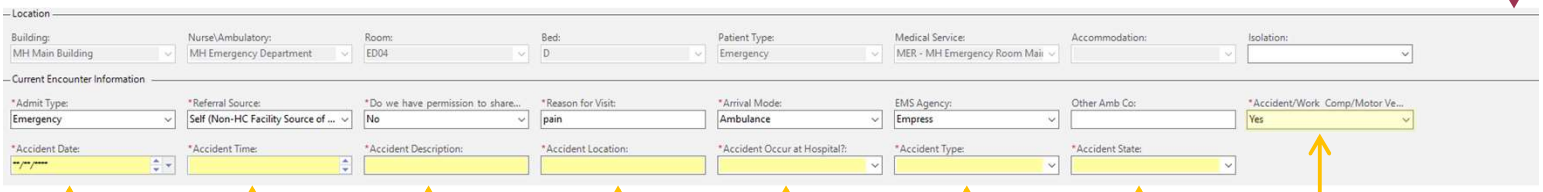
Patient Information Tab

Always Confirm all information with the patient.
When entering a room.



Encounter Tab

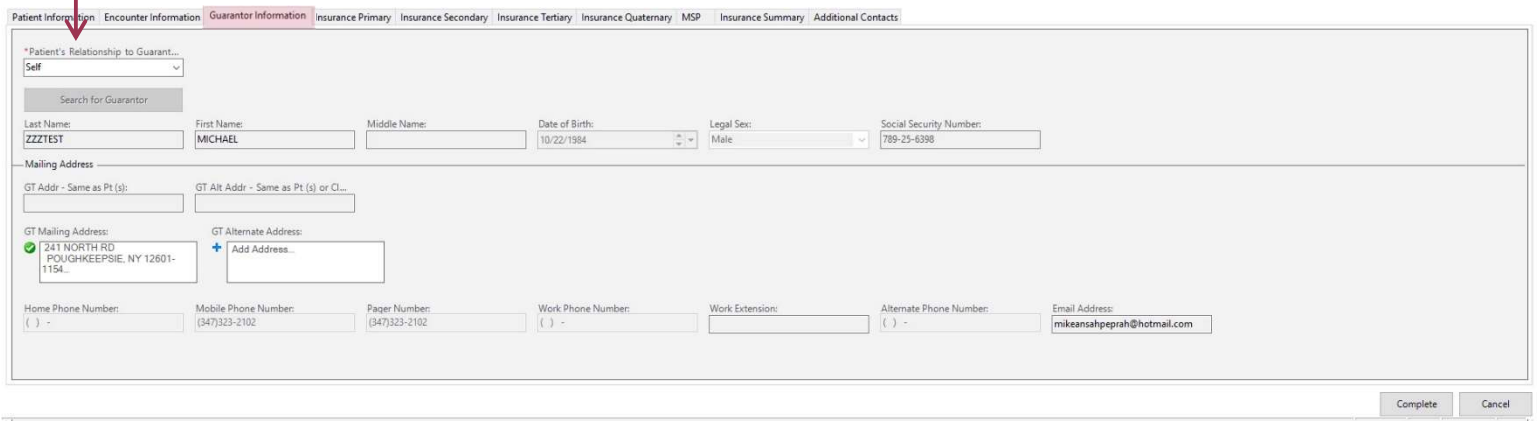




If answered yes to work related injury or Motor Vehicle accident, you must fill in all required fields highlighted in yellow.

Guarantor Tab

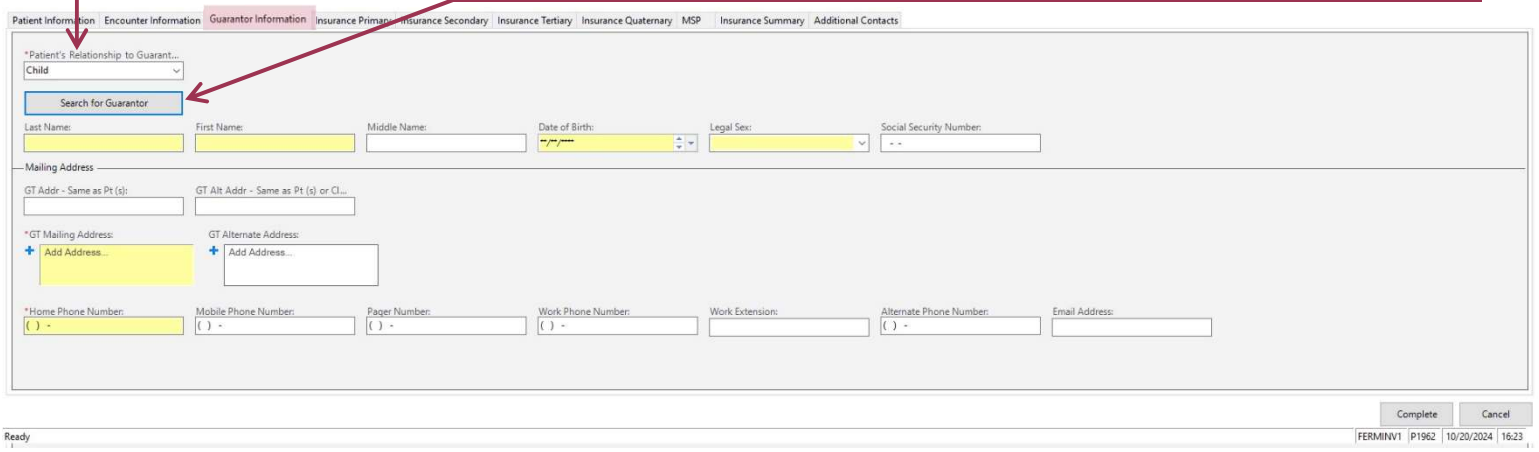
Guarantor Information:
Patient 18 and older is always self.



When the patient is over 18 years old, there is nothing to fill out. You must select "Self"

Guarantor Information:
Patient 18 and older is always self.

Search Relationship To Guarantor:
If the patient is 17 and younger, a guarantor must be listed. Search the Guarantor, to see if the Guarantor has an account in our system. If not, fill in the blanks.



Patient 17 years of age and younger a parent or legal guardian must be entered.

Insurance Tab

Section 1
Insurance Information:

Select the relationship of the primary policy holder. (Self, Mother, Father, Spouse, etc.)

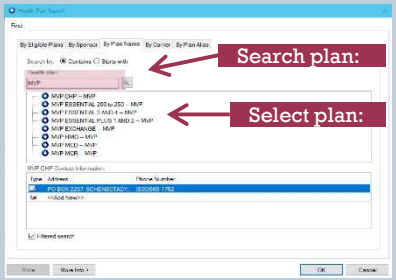
If the patient is not the primary holder of the insurance, search for subscriber. Search using name and Date of Birth. If the subscriber is not in our system, you will then enter all highlighted areas required.
The system will allow up to 4 different insurance plans to be entered.

Section 2
Employment Status:

Select the patient's employment status. (Employed, Unemployed, Retired, etc.). When selecting employed, you must search employer and fill in all the highlighted areas.

Section 3
Health plan:

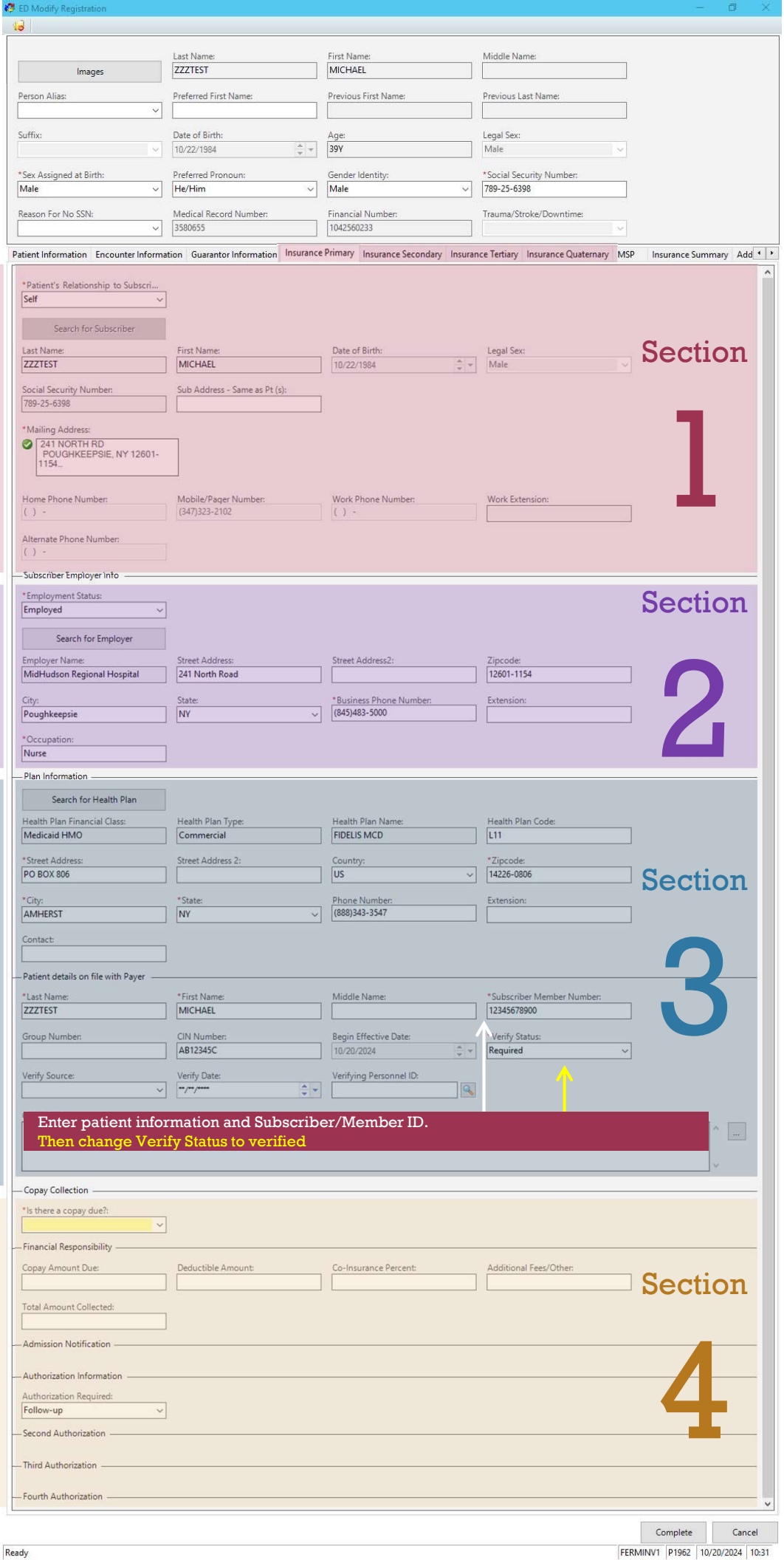
Here you will list the insurance the patient is covered under by clicking on "Search Health Plan"
When the popup screen is displayed Enter the insurance name and select the correct insurance plan.(See image below)



Section 4
Co Payment:

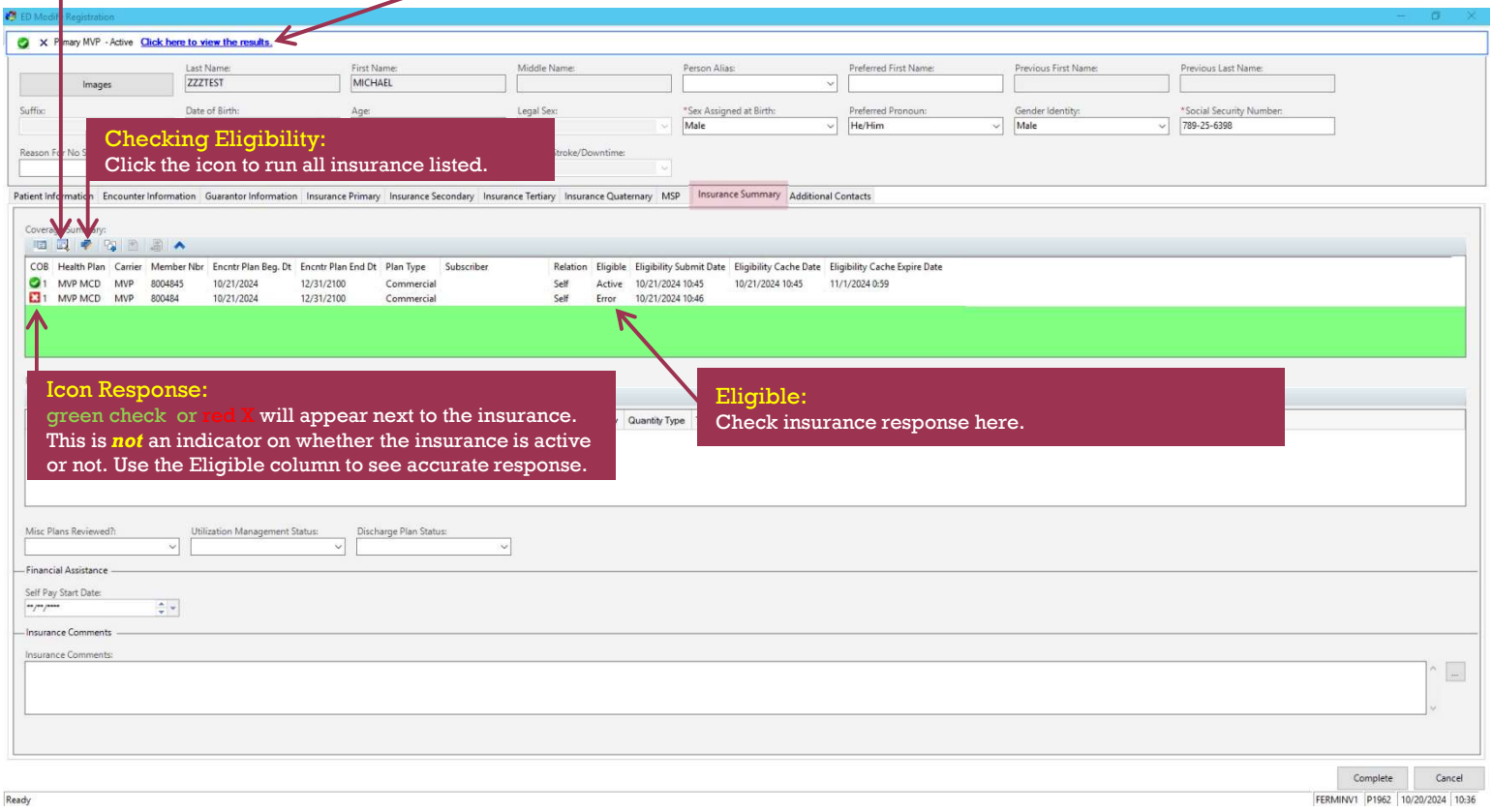
Here you enter copay information.
- Is there a copay due?
- Copay amount due
- Total Amount Collected

Authorization Required:
This defaults to "Follow-Up" we should never have to change it.



Insurance Summary Tab

Results:
Get more details like copay and insurance type

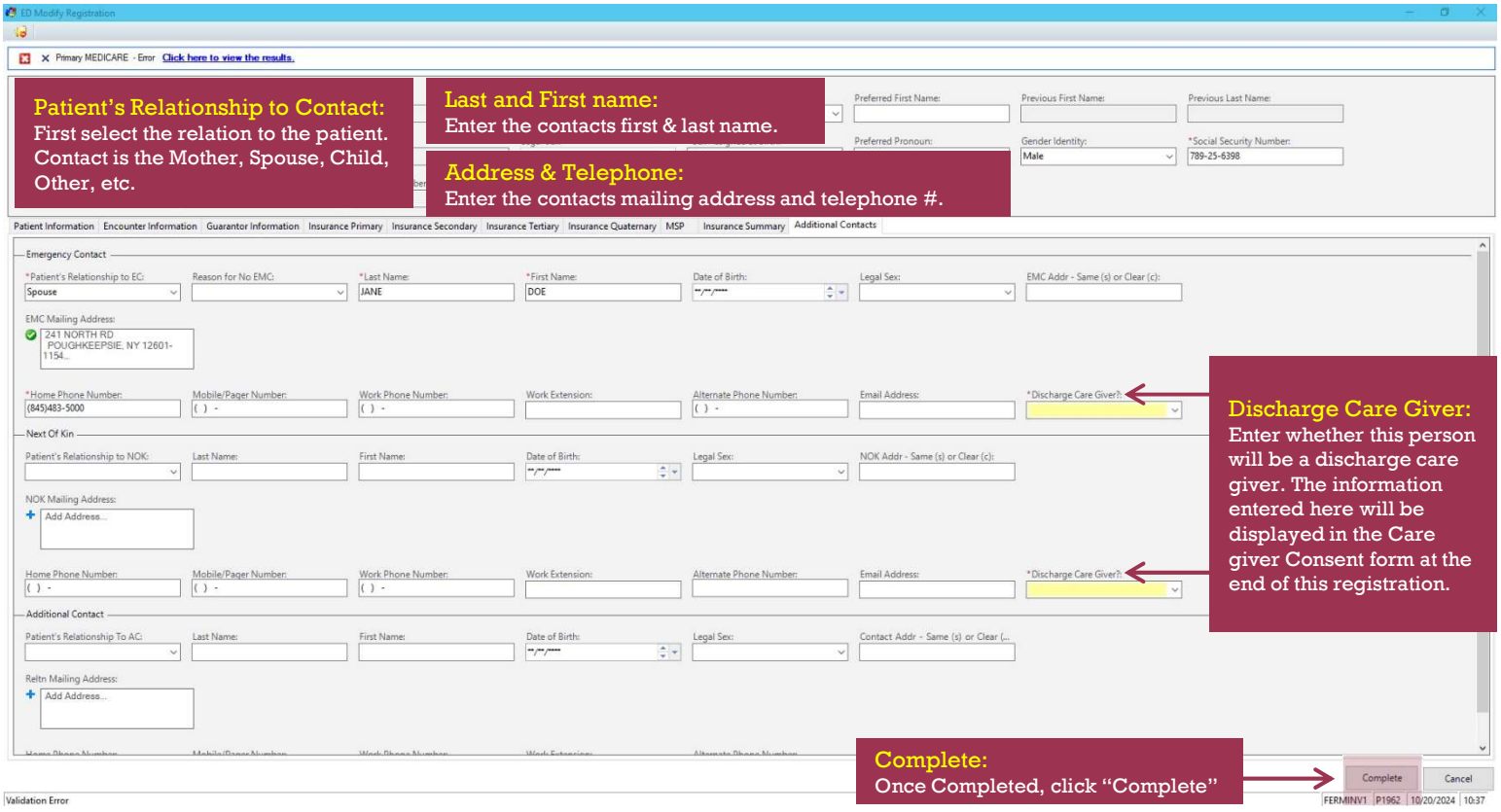


Checking Eligibility:
Click the icon to run all insurance listed.

Icon Response:
green check or red X will appear next to the insurance. This is ***not*** an indicator on whether the insurance is active or not. Use the Eligible column to see accurate response.

Eligible:
Check insurance response here.

Additional Contacts

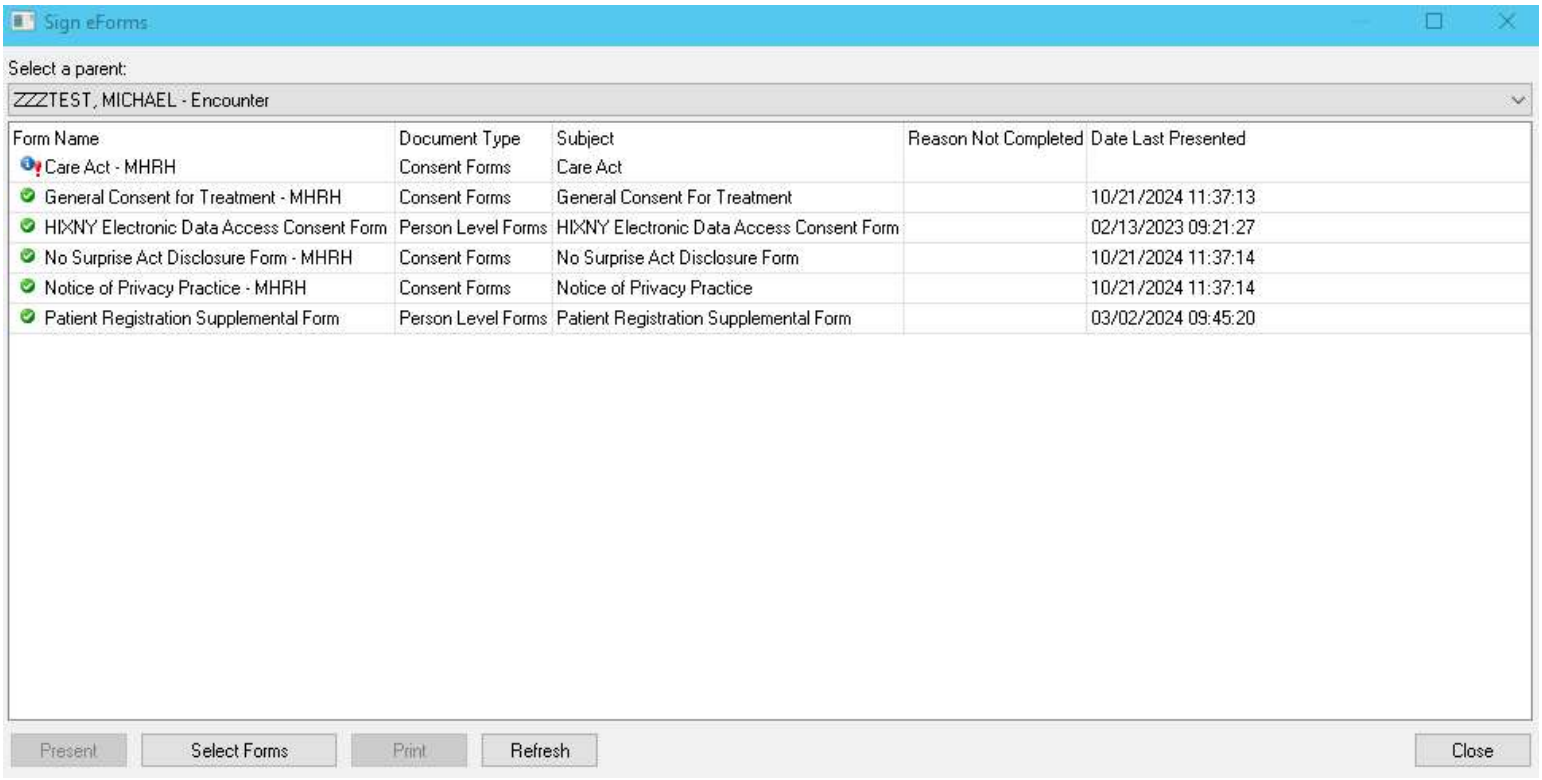


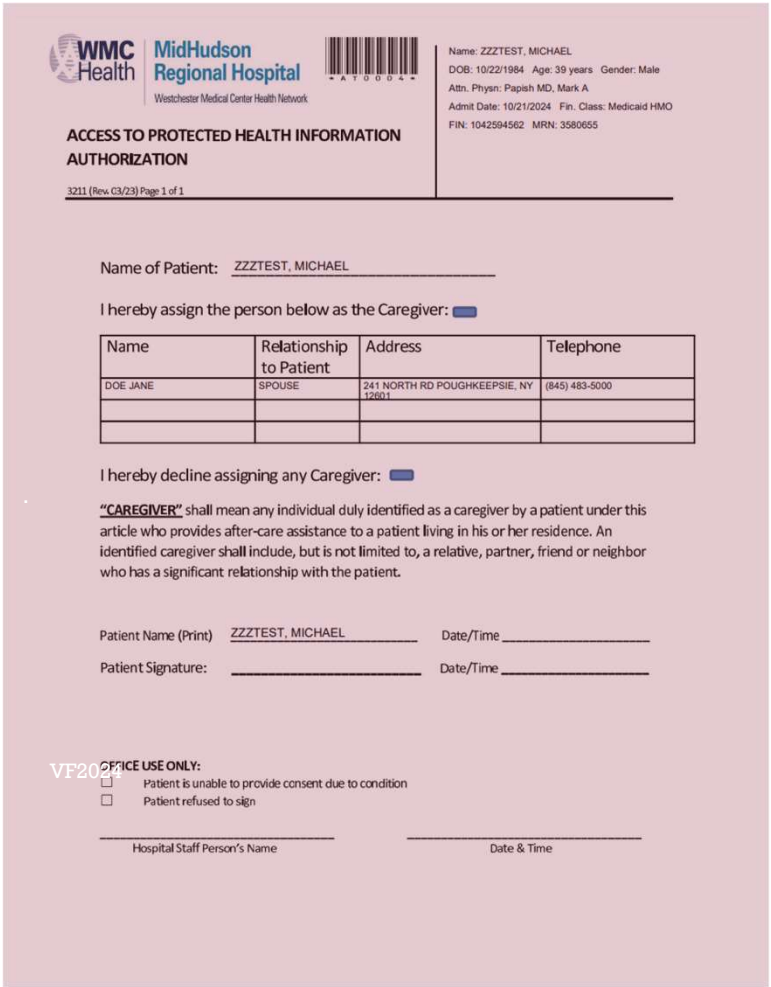
There can be up to 3 additional contacts listed.

- Emergency Contact
- Next Of Kin
- Additional Contact

eForms

Any missing consent forms will appear on this popup. All missing consent must be obtained. You can use the attached Wacom tablet or iPad to collect signatures





WMC Health | MidHudson Regional Hospital
Westchester Medical Center Health Network

Name: ZZZTEST, MICHAEL
DOB: 10/22/1984 Age: 39 years Gender: Male
Attn. Physn: Papish MD, Mark A
Admit Date: 10/21/2024 Fin. Class: Medicaid HMO
FIN: 1042594562 MRN: 3580655

ACCESS TO PROTECTED HEALTH INFORMATION AUTHORIZATION

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Name of Patient: ZZZTEST, MICHAEL

I hereby assign the person below as the Caregiver:

Name	Relationship to Patient	Address	Telephone
DOE JANE	SPOUSE	241 NORTH RD POUGHKEEPSIE, NY 12601	(845) 483-5000

I hereby decline assigning any Caregiver:

"CAREGIVER" shall mean any individual duly identified as a caregiver by a patient under this article who provides after-care assistance to a patient living in his or her residence. An identified caregiver shall include, but is not limited to, a relative, partner, friend or neighbor who has a significant relationship with the patient.

Patient Name (Print) ZZZTEST, MICHAEL Date/Time

Patient Signature: Date/Time

OFFICE USE ONLY:
☐ Patient is unable to provide consent due to condition
☐ Patient refused to sign

Hospital Staff Person's Name

Date & Time

Discharge Care Giver Form: All the information entered in the additional contact tab will appear here at the end.

VF2024