THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2017

PROCESSING NOTES & LEGEND FOR SUBMISSIONS OF THE FY 2017 PATIENT ORIGIN SURVEY DATA SUPPLEMENT
MUST INCLUDE DISCHARGE DATA FOR OCTOBER 1, 2016 - SEPTEMBER 30, 2017

The Patient Origin section of the annual report submitted on behalf of hospitals (Form BHD 134A) shall be submitted as a separate file/document. This data shall be submitted only in Microsoft Excel (v. 2003 or later) or CSV formats. All submissions must comply with the filing requirements set forth in Ala. Admin. Code 410-1-3-.09. Submission must include the cover sheet located in this report. Both the Annual Report (Form BHD 134A) AND the Patient Origin data electronic file must be submitted for the annual report to be deemed materially complete by the Agency. A provider whose report is deemed materially incomplete by the Agency is subject to penalties as defined in Ala. Admin. Code 410-1-3-.11.

FIELD NAME (electronic & paper submissions)	**INSTRUCTIONS (electronic & paper submissions)**	**FIELD LENGTH (for electronic submissions only)** **Field Length Requirements**
Hospital ID #	SHPDA Hospital ID number	
Patient Number	Patient identification number. *This number may be a blind number assigned in sequential order.* Patient ID numbers **cannot** be duplicated.	**6**
Age	The numeric value of the patient's age, consisting of three (3) digits. For example, if the patient is 78, the entry would be 078. If the patient is 103, the entry would be 103. ***INCLUDE ALL NEWBORNS & PEDIATRICS, USING 000 FOR ALL INFANTS UNDER 1 YEAR OF AGE.***	**3**
Sex	Use the following values: ***MALE:*** **1** ***FEMALE:*** **2**	**1**

FIELD NAME (electronic & paper submissions)	**INSTRUCTIONS (electronic & paper submissions)**	**FIELD LENGTH (for electronic submissions only)** **Field Length Requirements**
Race or National Origin	Use the following values: ***WHITE/CAUCASIAN*** ---------- **1** ***BLACK/AFRICAN AMERICAN/NEGRO*** ---------- **2** ***HISPANIC/SPANISH/LATINO*** ---------- **3** ***ASIAN*** ---------- **4** ***AMERICAN INDIAN/ALASKAN NATIVE*** ---------- **5** ***PACIFIC ISLANDER*** ---------- **6** ***INDIA*** ---------- **7** ***MIDDLE EASTERN*** ---------- **8** ***OTHER*** ---------- **9**	**1**
Zip Code	Patient's residence zip code. **5 digits only, report unknown zip codes as "99999".**	**5**
Length of Stay (LOS)	The number of days calculated from the date of admission until the date of discharge or death. **Discharges for this year** include any patients admitted in previous years and discharged during the current reporting period. Patients must be in the hospital a minimum of 24 hours to be included in the Patient Origin Survey. ***Examples:*** A patient admitted on April 30th and discharged on May 4th would have a LOS of 004. A patient admitted on May 3rd and discharged on May 13th would have a LOS of 010. A patient admitted on September 28th and not discharged by September 30th would not be included.	**3**
Date of Discharge	For every discharge, Please include the date of discharge for that patient. This should be submitted in a **MM/DD/YYYY** format.	**10**

FIELD NAME (electronic & paper submissions)	**INSTRUCTIONS (electronic & paper submissions)**	**FIELD LENGTH (for electronic submissions only)** **Field Length Requirements**
Service Code	Record only the ***PRIMARY*** service when more than one clinical service is provided during the hospital stay: ***MEDICINE:*** **01** ***SURGERY:*** **02** ***PEDIATRICS:*** **03** (use only if your facility has an organized pediatric unit and only for patients 17 and under). If your facility does not have an organized pediatric unit, report services under one of the remaining codes. For patients 18 and older, report under one of the remaining codes even if treatment occurred in an organized pediatric unit. ***GYNECOLOGY*** **04** *(NO MALES)*, (medicine or surgery) ***OBSTETRICS*** **05** *(NO MALES)* ***ORTHOPEDICS*** **06** (use only if your facility has an organized orthopedic unit.) Facilities without an organized orthopedic unit should report these patients under the appropriate service. ***PSYCHIATRIC*** **07** (include alcoholism and substance abuse treatments) ***REHABILITATION*** **08** ***OTHER*** **09**	**2**
DRG/CMG	Patient's ***DRG*** (Diagnosis Related Group) or ***CMG*** (Case Mix Group) code. **As a reminder, please indicate which version of DRG codes your facility is using.**	**4** (add leading 0's as necessary)

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Payer Source	Use the following values: ***SELF PAY/PRIVATE PAY*---------- 1** ***WORKMAN'S COMPENSATION*---------- 2** ***MEDICARE*---------- 3** ***MEDICAID*---------- 4** ***TRI-CARE*---------- 5** ***BLUE CROSS/BLUE SHIELD*---------- 6** ***NO CHARGE/CHARITY*---------- 7** ***HMO*---------- 8** ***ALL KIDS*---------- 9** ***OTHER INSURANCE*---------- 10** ***HOSPICE*---------- 11** ***MEDICARE ADVANTAGE*---------- 12** ***OTHER*---------- 13**	**2**
ICD-10	Patient's **ICD-10** primary diagnosis code. Please report the full 7 digit ICD code **WITHOUT THE DECIMAL POINT**	**7**

FORM BHD 134A
Revised 05/2016

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FY 2017
HOSPITAL PATIENT ORIGIN SURVEY CLOSEOUT RECORD

Please include this sheet as a cover to the FY 2017 Hospital Patient Origin Survey for all submissions. This survey is due by November 30, 2017.

Hospital Name _____

Hospital ID # _____

Name of Person Responsible: _____

Title _____

Telephone Number _____

Version of **DRG** Codes: _____