

Public Health Program Beneficiary Employer Disclosure Law

Instructions:

The file is to be provided in .CSV format, including one header record followed by all detail records
 All Dates to be provided in MM/DD/YYYY format
 Total Charges Format to be provided as digits only with a single decimal point and 2 digits after the decimal
 All Other fields to be provided in Text Format

Do NOT include patients who have ANY third-party health insurance coverage
 Do NOT include patients retroactively enrolled in Medicaid
 Do NOT include patient names

Header Record - One per file

1. Use State Provider Identification number.
2. Provide Hospital/System Name.
3. Provide Hospital Address
4. Provide Reporting Period Start Date
5. Provide Reporting Period End Date
6. Provide Hospital Contact Person
7. Provide Hospital Contact Person Phone Number

Detail Records - Multiple Per File

1. Develop and use an alpha or numeric identifier for each patient obtaining hospital services (include both inpatient and outpatient).
2. Report the patient's discharge date (inpatient) or the service date (outpatient).
3. Answer yes or no if the patient is the responsible party for payment.
4. Report the name, if known, of the patient's employer. If multiple employers, list each by creating a separate detail record for each employer.
 Show the encounter dollar amount only on first record (See example for 122334455 below). If employer unknown, insert "not available".
 If no employer, insert "none"
5. If the responsible party is not the patient, answer yes or no if the responsible party is employed.
6. Report the name, if known, of the responsible party's employer. If multiple employers, list each by creating a separate detail record for each employer.
 Show the encounter dollar amount only on first record (See example for 122334455 below). If employer unknown, insert "not available".
 If no employer, insert "none"
7. Report total charges for the encounter

Formats

Header Record

Hospital Provider ID	Hospital/System Name	Address	Reporting Period Start	Reporting Period End	Hospital Contact	Contact Phone
EXAMPLE: 112233445566	ABC Medical Center	333 Oak St,	08/01/2005	03/31/06	Jane Smith	217-555-3455

Detail Records

<u>Patient ID</u>	<u>Patient Discharge or Service Date</u>	<u>Is The Patient The Responsible Party?</u>	<u>Patient's Employer Name</u>	<u>Is The Responsible Party Employed?</u>	<u>Responsible Party's Employer Name</u>	<u>Total Charges for Encounter</u>
EXAMPLES: ABC12345	03/10/2006	Yes	Joe's Café	Yes	Joe's Café	2,000
AAA34563	12/15/2005	No	None	Yes	Jiffy Diner	3,000
478245679	09/11/2005	Yes	Not Available	Yes	Not Available	4,000
29009090901A	08/15/2005	No	None	No	None	3,000
999023129BV1	02/15/2006	No	ABC Company Inc	Yes	Jack's Trucking	1,800
23567AQ	02/21/2006	Yes	None	No	None	1,399
122334455	09/22/2005	Yes	Widgets Inc.	Yes	Widgets Inc	3,345
122334455	09/22/2005	Yes	Bob's Booksellers	Yes	Bob's Booksellers	0
JKL194566	02/21/2006	Yes	None	No	None	464