OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
AMBULATORY SURGERY DATA RECORD
MANUAL ABSTRACT REPORTING FORM

For use with encounter visits on or after October 1, 2004

Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements (Title 22, Sections 97251 through 97265)

A. FACILITY ID NUMBER

B. ABSTRACT RECORD NUMBER (Optional)

1. DATE OF BIRTH

Month Day Year (4-digit)
M M D D C C Y Y

2. SEX
F Female
M Male
U Unknown

3. RACE
R1 American Indian or Alaska Native
R2 Asian
R3 Black or African American
R4 Native Hawaiian or Other Pacific Islander
R5 White
R9 Other Race
99 Unknown

4. ETHNICITY
E1 Hispanic or Latino
E2 Non-Hispanic or Non-Latino
99 Unknown

5. ZIP CODE

99999 = Unknown

6. PATIENT'S SOCIAL SECURITY NUMBER

Report 000000001(Unknown) **if not recorded in the patient's medical record**

7. SERVICE DATE

Month Day Year (4-digit)
M M D D C C Y Y

8. PRINCIPAL DIAGNOSIS
ICD-9-CM CODE

9. OTHER DIAGNOSES
ICD-9-CM CODE
a.
b.
c.
d.
e.
f.
g.
h.
i.
j.

10. PRINCIPAL E-CODE
ICD-9-CM CODE
E

11. OTHER E-CODES
ICD-9-CM CODE
a. E
b. E
c. E
d. E
e. E
f. E

12. PRINCIPAL PROCEDURE
CPT-4 CODE

13. OTHER PROCEDURES
CPT-4 CODE
a.
b.
c.
d.
e.
f.
g.
h.
i.
j.

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A. FACILITY ID NUMBER

B. ABSTRACT RECORD NUMBER (Optional)

1. DATE OF BIRTH (MMDDCCYY)

7. SERVICE DATE (MMDDCCYY)

9. OTHER DIAGNOSES
ICD-9-CM CODE

k.
l.
m.
n.
o.
p.
q.
r.
s.
t.
u.
v.
w.
x.
y.

13. OTHER PROCEDURES
CPT-4 CODE

k.
l.
m.
n.
o.
p.
q.
r.
s.
t.
u.

14. DISPOSITION OF PATIENT

01 Discharged to home or self care (routine discharge)
02 Discharged/transferred to another short term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF)
04 Discharged/transferred to an intermediate care facility (ICF)
05 Discharged/transferred to another type of institution for inpatient care
06 Discharged/transferred to home under care of organized home health service org.
07 Left against medical advice or discontinued care
08 Discharged/transferred to home under care of a Home Intravenous (IV) provider
20 Expired
43 Discharged/transferred to a federal hospital
50 Discharged home with hospice care
51 Discharged to a medical facility with hospice care
61 Discharged to hospital-based Medicare approved swing bed
62 Discharged/transferred to another rehabilitation facility including rehabilitation distinct part unit of a hospital
63 Discharged/transferred to a long term care hospital
64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
00 Other

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1. DATE OF BIRTH (MMDDCCYY)

7. SERVICE DATE (MMDDCCYY)

15. EXPECTED SOURCE OF PAYMENT

09 Self Pay
11 Other Non-federal programs
12 Preferred Provider Organization (PPO)
13 Point of Service (POS)
14 Exclusive Provider Organization (EPO)
16 Health Maintenance Organization (HMO) Medicare Risk
AM Automobile Medical
BL Blue Cross/Blue Shield
CH CHAMPUS (TRICARE)
CI Commercial Insurance Company
DS Disability
HM Health Maintenance Organization
MA Medicare Part A
MB Medicare Part B
MC Medicaid (Medi-Cal or Medi-Cal Managed Care Plan)
OF Other federal program
TV Title V
VA Veterans Affairs Plan
WC Workers' Compensation Health Claim
00 Other

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