IHE Patient Care Coordination (PCC) White Paper

Patient Registration Demographics Data Capture and Exchange

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Foreword

Integrating the Healthcare Enterprise (IHE) is an international initiative to promote the use of standards to achieve interoperability among health information technology (HIT) systems and effective use of electronic health records (EHRs). IHE provides a forum for care providers, HIT experts and other stakeholders in several clinical and operational domains to reach consensus on standards-based solutions to critical interoperability issues.

The primary output of IHE is system implementation guides, called IHE Profiles. IHE publishes each profile through a well-defined process of public review and trial implementation and gathers profiles that have reached final text status into an IHE Technical Frameworks.

This white paper is published on September 27, 2017. Comments are invited and can be submitted at http://www.ihe.net/PCC_Public_Comments.

General information about IHE can be found at http://ihe.net.

Information about the IHE Patient Care Coordination domain can be found at http://ihe.net/IHE_Domains.

Information about the organization of IHE Technical Frameworks and Supplements and the process used to create them can be found at http://ihe.net/IHE_Process and http://ihe.net/Profiles.

The current version of the IHE Patient Care Coordination Technical Framework can be found at http://ihe.net/Technical_Frameworks.
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1 Introduction

The IHE PCC Patient Registration Demographics Data Capture and Exchange White Paper describes the requirements and constraints for patient demographic data that should be collected and exchanged for patient registration. However, these data requirements may be proposed to be published as a future IHE Technical Framework Volume 4 US National Extension to the IHE ITI Patient Administration Management (PAM) Profile for the message-based data exchange.

In addition to patient demographic data, provider and encounter demographics, insurance and payment data are also captured and exchanged during patient registration. The workflow and requirements for these data elements are specified in the AHIMA Patient Registration Use Case. We propose that the US National Extension to the IHE ITI PAM Profile also include detailed requirements and constraints on these other data elements.

1.1 Open Issues and Questions

Open issue 1. Cross Enterprise Master Patient Index (C-EMPI) Identifier should be added to the list of identifiers specified in the AHIMA Patient Registration Use Case data requirements as follows (see Note 1 below):

- Enterprise Master Patient Index (EMPI) Identifier
- Medical Record Number (MRN)
- Episode of Care Number
- Visit Encounter Number (Account Number)
- Previsit Number

Open Issue 2. Administrative Sex - Discuss with HL7 (table 4.1.1.1-3):

1. What does “other”, "not applicable", and “unknown” mean for Administrative Sex values?
2. Add “Patient Declined to Answer”

Open Issue 3. Race - Discuss with HL7 (Table 4.1.1.1-4):

1. Add “Unknown”
2. Add “Patient Declined to Answer”

Open Issue 4: There is a need to verify with ITI PAM developers if PAM has the security component and how this should be addressed in the US National Extension to PAM Profile.

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1.2 Purpose of the White Paper

This white paper is focused on specifying patient demographic data elements that should be collected and exchanged for patient registration during an emergency visit at a healthcare organization. This white paper provides the detailed requirements and constraints on the relevant HL7®2 v2.5.1 segments from the IHE ITI PAM Profile for the patient demographic data.

1.3 Intended Audience

The intended audience of the IHE PCC Patient Registration Demographics Capture and Exchange white paper is:

- IT departments of healthcare institutions
- Technical staff of vendors participating in the IHE initiative
- Experts involved in standards development
- Those interested in integrating healthcare information systems and workflows

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2 HL7 is the registered trademark of Health Level Seven International.
2 Patient Registration

2.1 Overview

Patient Registration is the process of checking-in a person to initiate the episode of care. Patient registration takes place in various healthcare settings and at the various functions of the episode of care. The Registration Department, Patient Access, Admitting Departments, Call Centers, or Online Scheduling Services, are responsible for management of patient registration activities. In some emergent situations when the identity of a patient is unknown, for example, trauma patient, unconscious patient, patient with acute condition (stroke, heart attack), child who was brought to the emergency department without a representative, patient registration can be conducted by other authorized staff, e.g., clinicians. In some cases, pre-registration may take place prior to the actual registration process at the healthcare organization. Pre-registration may happen as a part of emergency management service (EMS) transport of the patient, before arriving to the emergency department, scheduling a procedure prior to the episode of care and/or a follow-up visit, etc.

During the patient registration, insurance verification and pre-authorization may take place. In this case, an insurance verifier is involved in verifying payment information as a part of the patient registration process.

Patient registration information is provided by the patient and/or by the patient’s designated (authorized, legal) representative (guardian) (parent, caregiver, decision-maker, etc.) to the registration staff. Information may also be received/uploaded from various data sources, e.g., Electronic Health Record (EHR) systems, Payor systems, Health Information Exchanges (HIE). The patient registration information can be provided verbally, via facility registration portal/kiosk, or phone interview.

Information collected at the registration initiates the creation of a new episode of care record. This information will be further used at the next functions of the episode of care (triage/assessment, testing, treatment, medication management and discharge/transfer).

A. The following is the list of scenarios that involve patient registration and exchange of visit information for Emergency Department (ED) visit:

1. Registration of walk-in/patient presentation in ED
2. Registration initiated/conducted by clinicians for life threatening situations
3. Registration for diagnostic testing during ED stay
4. Registration for medication administration
5. Registration for pre-admission of patients into the hospital
6. Sending visit information for follow-up care

B. In-patient setting visit (hospitals):

1. Registration for planned admission
2. Registration for unplanned admission
3. Registration for diagnostic testing during hospital stay
4. Registration for medication administration
5. Registration for treatment during hospital stay
6. Registration/Scheduling for post-acute care follow-up

C. Out-patient setting visit:
   1. Registration for walk-in/patient presentation
   2. Registration/Scheduling for planned visit
   3. Registration/Scheduling for diagnostic testing (during the visit, and after the visit)
   4. Registration/Scheduling for treatment including observation services (during the visit, and after the visit)
   5. Registration for medication administration
   6. Registration for post-visit follow-up

This white paper focuses on **Scenario A1: Registration of Walk-in/Patient Presentation in ED.**

### 2.2 Use Case

#### 2.2.1 Use Case #1: Registration of Walk-in/Patient Presentation in ED

Patient presents to the ED, conscious and able to provide identification. Registration staff (Patient Access staff) collect identifying information necessary to register patient. Registration is completed, Patient registration information is captured in EHR.

Table 2.2.1-1 below presents the description of the use case from the user perspectives. It describes business actors (humans) and technical actors (information systems) involved in the patient registration; workflow steps; information collected; entry and exit conditions and quality requirements. Please note that a patient care cannot be delayed if insurance information is not available at registration as per the Emergency Medical Treatment and Labor Act (EMTALA).³

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Table 2.2.1-1: Patient Registration Use Case Workflow and Corresponding Information
(Italic font and grey highlight indicates steps performed/data created by Technical Actors)

<table>
<thead>
<tr>
<th>Use Case Name: Registration of Walk-in/Patient Presentation in ED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Actors</strong></td>
</tr>
<tr>
<td>Technical Actors: Registration-Admission/Discharge/Transfer (R-ADT) System, Health Information System (HIS), Financial System, Payor System, Electronic Health Record (EHR) system, Electronic Document Management System (EDMS), Health Information Exchange (HIE), Personal Health Record (PHR), Mobile Health Application (mHealth App).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step #</th>
<th>Workflow Steps</th>
<th>Information Items (Documents/Records/Data)</th>
</tr>
</thead>
</table>
| 1.     | Patient is triaged and presents to ED registration staff. | 1. Patient Name  
2. **DOB**  
3. Reason for visit  
4. Consent for treatment (can be implied)  
5. Advanced Beneficiary Notice (ABN) |
| 2.     | Patient presents to the Registration staff. | Patient Registration Record  
1. Patient demographics (e.g., name, DoB, address)  
2. Visit demographics (e.g., enterprise medical record number, date/time of encounter, reason for visit, list of barcodes, etc.)  
3. Physician demographics (name, PID, department/service)  
4. Reason for visit  
5. Consents for visit (procedure, treatment, etc., may be implied consent) |
| 3.     | Registration staff identifies patient, asks patient to complete necessary forms (paper or electronic), and checks in/registers the visit in R-ADT System. In the case of “trauma/unidentified patient”, registration staff assigns a tag with the ID number to be used in the episode of care. | 1. Consent for information sharing  
2. eSignature for Registration Staff  
3. Wristband (patient ID bracelet)  
4. Risk Management (RM)/Infection Control (IC)/Public Health/Population Health (PH) information  
5. Audit Record: Who, When, Why, What |
| 4.     | **HIS creates an audit record of the encounter.** | |
| 5.     | **R-ADT System searches and obtains patient and visit-relevant information from various systems (HIS, EHR, Financial Systems, EDMS, HIE, PHR, mHealth app).** | 6. Consent for information sharing  
7. eSignature for Registration Staff  
8. Wristband (patient ID bracelet)  
9. **Risk Management (RM)/Infection Control (IC)/Public Health/Population Health (PH) information**  
10. **Audit Record: Who, When, Why, What** |
| 6.     | Registration staff validates patient information, prints ID bracelet and corresponding labels with barcodes for the patient, and staff signs the record with e-signature or in ink. Registration staff sends patient to Insurance verifier or conduct insurance verification. | Insurance information:  
1. Payor demographic  
2. Insurance ID  
3. Authorization to bill insurance  
4. Coverage |
<p>| 7.     | Insurance verification is conducted by the Registration staff or Insurance Verifier. | |
| 8.     | Registration staff or Insurance Verifier verifies patient insurance information; contacts payor, if needed; obtains authorization; and requests/collects co-pay or | |</p>
<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>R-ADT System communicates with the payor system directly or via HIE to obtain patient insurance information. Patient information is updated in the Financial System.</td>
</tr>
<tr>
<td>10</td>
<td>R-ADT System updates patient information in PHR via mHealth app.</td>
</tr>
<tr>
<td>11</td>
<td>Registration staff assembles all documents necessary for the episode of care and completes the registration by signing the Episode of Care Record with e-Signature in EHR. This may be done automatically when the staff completes the record (all data are entered and verified) and closes the registration record for this patient. Staff sends patient to clinician for assessment. Clinician opens patient record to begin assessment and sends the acknowledgement of receipt.</td>
</tr>
<tr>
<td>12</td>
<td>Registration information is uploaded into EHR. EHR sends Notification of Record Availability to clinician.</td>
</tr>
<tr>
<td>13</td>
<td>EHR sends back to the R-ADT the Acknowledgement of Receipt.</td>
</tr>
<tr>
<td>14</td>
<td>Audit trail for the personnel and systems involved in patient registration is completed in HIS.</td>
</tr>
</tbody>
</table>

Entry Condition: Pre-registration may happen as a part of EMS transport of the patient, pre-registration of the patient before arriving to the emergency department.

Exit Condition: After the data is available, the HIS/EHR will contain a record that can be used for the patient care function as well as the audit trail record.

Quality Requirements: Real time patient information verification.

### 2.2.2 Process Flow

This use case covers the process of registering a walk-in patient upon presentation in the Emergency Department. The patient may be new or known to the current healthcare facility. The following sequence of steps replicated from the IHE ITI PAM Profile, describes the typical
process flow when a request is made to register the patient, or update the patient’s demographic information.

![Basic Process Flow in Patient Registration Use Case](image)

**Figure 2.2.2-1: Basic Process Flow in Patient Registration Use Case**

**Pre-conditions:**
Pre-registration may happen as a part of EMS transport of the patient, pre-registration of the patient before arriving to the emergency department.

**Post-conditions:**
After the data is available, the HIS will contain a record that can be used for the episode of care functions (e.g., triage, diagnostic testing, medication administration, etc.) as well as the audit trail record.

**2.2.3 Information Content**
The information items (documents/records/data) that are collected during patient registration are shown in Table 2.2.3-1.
Table 2.2.3-1: Patient Registration Information

<table>
<thead>
<tr>
<th><strong>Patient Registration Information</strong></th>
<th><strong>Insurance Information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient demographics (e.g., name, DoB, address, biometrics)</td>
<td>Payor demographic</td>
</tr>
<tr>
<td>Visit demographics (enterprise medical record number, date/time of encounter, reason for visit, list of barcodes, etc.)</td>
<td>Insurance ID</td>
</tr>
<tr>
<td>Physician demographics (name, PID, department/service)</td>
<td>Coverage</td>
</tr>
<tr>
<td>Chief complaint, Reason for visit, ABN</td>
<td>Co-pay</td>
</tr>
<tr>
<td>Consent for visit</td>
<td>eSignature for Insurance Verifier</td>
</tr>
<tr>
<td>Consent for information sharing</td>
<td><strong>Payment Information</strong></td>
</tr>
<tr>
<td>eSignature for Registration Staff</td>
<td>Invoice for service</td>
</tr>
<tr>
<td>Wristband (patient ID bracelet with barcodes)</td>
<td>Payment receipt</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Risk Management/Infection Control/Public Health/Population Health Information</strong></th>
<th><strong>Audit Record</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you been out of the country in the last three weeks?</td>
<td>Who, When, Why, What</td>
</tr>
</tbody>
</table>

Please note that during patient registration, clinical information may be collected; however, this information is out of scope for the Patient Registration Use Case.
3 Overview of Proposed National Extension to the Technical Framework

The goal of IHE is to promote implementation of standards-based solutions to improve workflow and access to information in support of optimal patient care. To that end, IHE encourages the development of IHE National Deployment Committees to address issues specific to local health systems, policies and traditions of care. The role of these organizations and information about how they are formed is available at http://www.ihe.net/Governance/#National_Deployment. The AHIMA Patient Registration Use Case specifies the workflow, data requirements and constraints for the proposed US National Extension to the ITI PAM Profile. The sections below capture the requirements for this proposal.

3.1 Scope of National Extensions

National extensions to the IHE Technical Framework are allowed in order to address specific local healthcare needs and promote the implementation of the IHE Technical Frameworks. They may add (though not relax) requirements that apply to the Technical Framework generally or to specific transactions, actors and integration profiles. Some examples of appropriate national extensions are:

- Require support of character sets and national languages
- Provide translation of IHE concepts or data fields from English into other national languages
- Extensions of patient or provider information to reflect policies regarding privacy and confidentiality
- Changes to institutional information and financial transactions to conform to national health system payment structures and support specific local care practices

All national extensions shall include concise descriptions of the local need they are intended to address. They shall identify the precise transactions, actors, integration profiles and sections of the Technical Framework to which they apply. And they must provide technical detail equivalent to that contained in the Technical Framework in describing the nature of the extension.

3.2 Process for Developing National Extensions

National extension documents are to be developed, approved and incorporated in the Technical Framework in coordination with the IHE Technical Committee and its annual cycle of activities in publishing and maintaining the Technical Framework. The first prerequisite for developing a national extension document is to establish a national IHE initiative and make information regarding its composition and activities available to other IHE initiatives.

Established IHE national initiatives may draft a document describing potential national extensions containing the general information outlined above. This draft document is submitted to the IHE Technical Committee for review and comment. Based on discussion with the
Technical Committee, they prepare and submit a finalized version of the document in appropriate format for incorporation into the Technical Framework. The publication of National Extensions is to be coordinated with the annual publication cycle of other Technical Framework documents in the relevant domain.

3.3 Process for Proposing Revisions to the Technical Framework

In addition to developing national extension documents to be incorporated in the Technical Framework, national IHE initiatives may also propose revisions to the global Technical Framework. These may take the form of changes to existing transactions, actors or integration profiles or the addition of new ones. Such general changes would be subject to approval by the IHE Technical and Planning Committees.

National extensions that are minor in scope, such as suggestions for clarifications or corrections to documentation, may be submitted throughout the year via the ongoing errata tracking process, called the Change Proposal Process.

More substantial revision proposals, such as proposals to add new integration profiles or major country-based extensions, should be submitted directly to the IHE Technical and Planning Committees via the process for submitting new proposals called the Profile Proposal Process.
4 Proposed National Extension for IHE United States

The proposed national extension documented in this section is planned to be used in conjunction with the definitions of integration profiles, actors and transactions provided in Volumes 1 through 3 of the IHE ITI Technical Framework. This section includes extensions and restrictions to effectively support the regional practice of healthcare in the United States.

This proposed ITI national extension document was developed by the AHIMA Standards Task Force and was authored under the sponsorship and supervision of Patient Care Coordination Committee. Based on the public comment outcomes, the proposal for the US national extension will be submitted to the IHE USA initiative. The point of contact for this proposal is:

Dr. Anna Orlova
American Health Information Management Association (AHIMA)
Senior Director, Standards
anna.orlova@ahima.org

4.1 IHE United States Proposed Scope of Changes

The proposed extensions, restrictions and extensions specified apply to the following IHE ITI profiles:

- ITI: Patient Administration Management (PAM)
- ITI: Patient Demographics Query (PDQ)

HL7 v2.5.1 events and segments used by the ITI PAM Profile are detailed in the IHE ITI Technical Framework Volume 2 which will be referred to as ITI TF-2 in the remainder of this section.

This section describes proposed constraints on HL7 v2.5.1 events and segments used for the AHIMA Patient Registration Use Case for patient demographic data exchange only. Some of these constraints would apply to all HL7 transactions. Others would only affect the [ITI-30] and [ITI-31] transactions.

The document narrows or specifies the use of events and segments mentioned in ITI TF-2. Each segment is displayed as a table with rows of data items for the AHIMA Patient Registration Demographic dataset. Columns respectively specify the use of the item (“Usage”) and its cardinalities (“Card”).

The “Usage” column follows the common codification of HL7 and IHE as follows:

- R Required. The data element values must be provided for the AHIMA Patient Registration Use Case environment
- RE Required but may be empty. The data element may be missing from the message, but must be provided if the sending application owns the information. If the conformant
sending application knows a value for the element, then it shall send that value. If the
conformant sending application does not know a value, then that element may be omitted.
Receiving applications shall be able to successfully process the message if the element is
omitted (no error message should be generated if the element is missing).

- **O** Optional. The usage for this data element within the message is not defined. This
  extension doesn’t impose any restrictions on the item which may or may not be managed
  by sending and receiving applications. The sending application may choose to populate
  the field; the receiving application may choose to ignore the field.

- **C** Conditional. This usage has an associated condition predicate. (See HL7 Version 2.5,
  Chapter 2, Section 2.12.6.6, "Condition Predicate"). If the predicate is satisfied: A
  compliant sending application shall populate the element. A compliant receiving
  application may ignore data in the element. It may raise an error if the element is not
  present.

  If the predicate is NOT satisfied: A compliant sending application shall NOT populate
  the element. A compliant receiving application shall NOT raise an error if the condition
  predicate is false and the element is not present, though it may raise an error if the
  element IS present.

- **CE** Conditional but may be empty. This usage has an associated condition predicate. (See
  HL7 Version 2.5, Chapter 2, Section 2.12.6.6, "Condition Predicate").

  If the predicate is satisfied: If the conforming sending application knows the required
  values for the element, then the application must populate the element. If the conforming
  sending application does not know the values required for this element, then the element
  shall be omitted. The conforming sending application must be capable of populating the
  element (when the predicate is true) for all ‘CE’ elements. If the element is present, the
  conformant receiving application may ignore the values of that element. If the element is
  not present, the conformant receiving application shall not raise an error due to the
  presence or absence of the element.

  If the predicate is NOT satisfied: The conformant sending application shall not populate
  the element. The conformant receiving application may raise an application error if the
  element is present.

- **X** Not Supported. Data element is supported in another data element available in the
  Segment (Table 4.1.1.1-1).

The “Card.” column includes the bracketed highest and lowest cardinalities.
The data type tables below list value sets for some of those data items. These lists (restricted,
extended or even edited as compared with the original ones established by HL7) include values
that are proposed for this extension.
4.1.1 Proposed Requirements on All HL7 V2.x Transactions

4.1.1.1 Patient Identification Segment

Standard Reference: HL7 Version 2.5.1, Chapter 3 (Section 3.4.2)

The PID segment from ITI Technical Framework Volume 2b ITI PAM Profile specification (Table 3.30-3) is used by all applications as the primary means of communicating patient identification information. This segment contains permanent patient identifying and demographic information that, for the most part, is not likely to change frequently. Please note that red text in the Usage column indicates a constraint on the ITI PAM Profile specification.

Table 4.1.1.1-1: PID - Patient Identification Segment

<table>
<thead>
<tr>
<th>SEQ</th>
<th>LEN</th>
<th>DT</th>
<th>Usage</th>
<th>Card.</th>
<th>RP/#</th>
<th>TBL#</th>
<th>ITEM#</th>
<th>ELEMENT NAME</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>SI</td>
<td>O</td>
<td>[0..1]</td>
<td></td>
<td></td>
<td>00104</td>
<td>Set ID – PID</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>20</td>
<td>CX</td>
<td>X</td>
<td>[0..0]</td>
<td></td>
<td></td>
<td>00105</td>
<td>Patient ID</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>250</td>
<td>CX</td>
<td>R</td>
<td>[1..*]</td>
<td>Y</td>
<td>00106</td>
<td>Patient Identifier List</td>
<td>Note 1</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>20</td>
<td>CX</td>
<td>X</td>
<td>[0..0]</td>
<td>Y</td>
<td>00107</td>
<td>Alternate Patient ID – PID</td>
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<td></td>
</tr>
<tr>
<td>5</td>
<td>250</td>
<td>XPN</td>
<td>R</td>
<td>[1..*]</td>
<td>Y</td>
<td>00108</td>
<td>Patient Name</td>
<td>Note 2</td>
<td></td>
</tr>
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<td>6</td>
<td>250</td>
<td>XPN</td>
<td>C</td>
<td>[0..1]</td>
<td>Y</td>
<td>00109</td>
<td>Mother’s Maiden Name</td>
<td>Note 3</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>26</td>
<td>TS</td>
<td>R</td>
<td>[1..1]</td>
<td></td>
<td>00110</td>
<td>Date/Time of Birth</td>
<td>Note 4</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>IS</td>
<td>R</td>
<td>[1..1]</td>
<td>0001</td>
<td>00111</td>
<td>Administrative Sex</td>
<td>Note 5</td>
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<td>[0..*]</td>
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<td>00112</td>
<td>Patient Alias</td>
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<tr>
<td>10</td>
<td>250</td>
<td>CE</td>
<td>R</td>
<td>[1..*]</td>
<td>Y</td>
<td>0005</td>
<td>00113</td>
<td>Race</td>
<td>Note 6</td>
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<td>11</td>
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<td>R</td>
<td>[1..*]</td>
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<td>00114</td>
<td>Patient Address</td>
<td>Note 7</td>
<td></td>
</tr>
<tr>
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<td>4</td>
<td>IS</td>
<td>X</td>
<td>[0..1]</td>
<td>0289</td>
<td>00115</td>
<td>County Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>250</td>
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<td>RE</td>
<td>[0..*]</td>
<td>Y</td>
<td>00116</td>
<td>Phone Number – Home</td>
<td>Note 8</td>
<td></td>
</tr>
<tr>
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<td>RE</td>
<td>[0..*]</td>
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<td>00117</td>
<td>Phone Number – Business</td>
<td>Note 9</td>
<td></td>
</tr>
<tr>
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<td>250</td>
<td>CE</td>
<td>R</td>
<td>[1..1]</td>
<td>0296</td>
<td>00118</td>
<td>Primary Language</td>
<td>Note 10</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>250</td>
<td>CE</td>
<td>O</td>
<td>[0..1]</td>
<td>0002</td>
<td>00119</td>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>250</td>
<td>CE</td>
<td>O</td>
<td>[0..1]</td>
<td>006</td>
<td>00120</td>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>250</td>
<td>CX</td>
<td>RE</td>
<td>[0..1]</td>
<td>00121</td>
<td>Patient Account Number</td>
<td>Note 11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SEQ</td>
<td>LEN</td>
<td>DT</td>
<td>Usage</td>
<td>Card.</td>
<td>RP#/</td>
<td>TBL#/</td>
<td>ITEM#/</td>
<td>ELEMENT NAME</td>
<td>Notes:</td>
</tr>
<tr>
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<td>-------</td>
<td>------</td>
<td>------</td>
<td>-------</td>
<td>--------</td>
<td>--------------</td>
<td>--------</td>
</tr>
<tr>
<td>19</td>
<td>16</td>
<td>ST</td>
<td>X</td>
<td>[0..1]</td>
<td></td>
<td></td>
<td>00122</td>
<td>SSN Number – Patient</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>25</td>
<td>DLN</td>
<td>X</td>
<td>[0..1]</td>
<td></td>
<td></td>
<td>00123</td>
<td>Driver’s License Number</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>250</td>
<td>CX</td>
<td>O</td>
<td>[0..*]</td>
<td>Y</td>
<td></td>
<td>00124</td>
<td>Mother’s Identifier</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>250</td>
<td>CE</td>
<td>R</td>
<td>[1..*]</td>
<td>Y</td>
<td>0189</td>
<td>00125</td>
<td>Ethnic Group</td>
<td>Note 12</td>
</tr>
<tr>
<td>23</td>
<td>250</td>
<td>ST</td>
<td>O</td>
<td>[0..1]</td>
<td></td>
<td></td>
<td>00126</td>
<td>Birth Place</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>1</td>
<td>ID</td>
<td>O</td>
<td>[0..1]</td>
<td>0136</td>
<td>00127</td>
<td>Multiple Birth Indicator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>2</td>
<td>NM</td>
<td>C</td>
<td>[0..1]</td>
<td></td>
<td></td>
<td>00128</td>
<td>Birth Order</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>250</td>
<td>CE</td>
<td>O</td>
<td>[0..*]</td>
<td>Y</td>
<td>0171</td>
<td>00129</td>
<td>Citizenship</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>250</td>
<td>CE</td>
<td>O</td>
<td>[0..1]</td>
<td>0172</td>
<td>00130</td>
<td>Veterans Military Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>250</td>
<td>CE</td>
<td>X</td>
<td>[0..0]</td>
<td>0212</td>
<td>00730</td>
<td>Nationality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>26</td>
<td>TS</td>
<td>CE</td>
<td>[0..1]</td>
<td>00740</td>
<td></td>
<td>Patient Death Date and Time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>1</td>
<td>ID</td>
<td>C</td>
<td>[0..1]</td>
<td>0136</td>
<td>00741</td>
<td>Patient Death Indicator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>1</td>
<td>ID</td>
<td>CE</td>
<td>[0..1]</td>
<td>0136</td>
<td>01535</td>
<td>Identity Unknown Indicator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>20</td>
<td>IS</td>
<td>CE</td>
<td>[0..*]</td>
<td>Y</td>
<td>0445</td>
<td>01536</td>
<td>Identity Reliability Code</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>26</td>
<td>TS</td>
<td>CE</td>
<td>[0..1]</td>
<td></td>
<td></td>
<td>01537</td>
<td>Last Update Date/Time</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>241</td>
<td>HD</td>
<td>O</td>
<td>[0..1]</td>
<td></td>
<td></td>
<td>01538</td>
<td>Last Update Facility</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>250</td>
<td>CE</td>
<td>CE</td>
<td>[0..1]</td>
<td>0446</td>
<td>01539</td>
<td>Species Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>250</td>
<td>CE</td>
<td>O</td>
<td>[0..1]</td>
<td>0447</td>
<td>01540</td>
<td>Breed Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>80</td>
<td>ST</td>
<td>O</td>
<td>[0..1]</td>
<td></td>
<td></td>
<td>01541</td>
<td>Strain</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>250</td>
<td>CE</td>
<td>O</td>
<td>[0..2]</td>
<td>2</td>
<td>0429</td>
<td>01542</td>
<td>Production Class Code</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>250</td>
<td>CWE</td>
<td>O</td>
<td>[0..*]</td>
<td>Y</td>
<td>0171</td>
<td>01840</td>
<td>Tribal Citizenship</td>
<td></td>
</tr>
</tbody>
</table>

In accordance with the HL7 Version 2.5.1 usage of this segment, fields PID-2 (Patient ID), PID-4 (Alternate Patient ID), PID-19 (SSN patient number) and PID-20 (Driver’s license number) are superseded by field PID-3; field PID-9 (Patient Alias) is superseded by field PID-5 (Patient Name); field PID-12 (County Code) is supported by county/parish component (PID-11 – Patient
Address); field PID-28 (Nationality) is superseded by field PID-26 (Citizenship) as shown below.

**PID-3 – Patient Identifier List (CX), required.** This field contains a list of identifiers (one or more) used by the healthcare facility to uniquely identify a patient.

**Note 1:** As shown in the constrained profile definition of data type CX in ITI TF-2x: Appendix N.1, subfields CX-1 “ID number”, CX-4 “Assigning authority” are required, and CX-5 “Identifier Type Code” is required if known for each identifier.

This field may be populated with various identifiers assigned to the patient by various assigning authorities.

The authorized values for subfield CX-5 “Identifier Type Code” are given in HL7 Table 0203 (HL7 Version 2.5.1, Chapter 2A, Section 2A.14.5).

Values commonly used for Identifier Type Code in the context of PID-3 for this extension are as follows:

- AN Account Number
- BR Birth Certificate number. Assigning authority is the birth state or national government that issues the Birth Certificate
- DL Driver’s license number. Assigning authority is the state
- PI Patient Internal Identifier assigned by the healthcare organization
- PPN Passport number
- PRC Permanent Resident Card Number
- SL State License. Assigning authority is the birth state or national
- SS Social Security Number
- VN Visit Number

In addition, the following may be used for visual verification of patient demographics validation:

- Photo - image of patient, or patient identity such as passport, driver’s license, state ID card, military ID to be used to identify the patient.
- Student ID Card- for college clinics
- Insurance Card
- Green Card– for US permanent residents
- Visa - for international patients

Above mentioned identifiers or other information from the identification documents listed above may be entered into the R-ADT system according to organization policies. If these patient
identifiers are entered into the system, the digital identity services guidelines\textsuperscript{4} for risk
management processes must be used.

Additional Requirements for Patient Record Identifiers:

- \textit{Enterprise Master Patient Index\textsuperscript{5} (EMPI) Identifier, required but may be empty}. A unique
  number issued by the health institution to its various facilities and their information
  systems to enable access to patient’s information across facilities’ information systems.
The EMPI is a patient identifier that is not encounter-specific. It allows for the
management of multiple patient identifiers across organizations and encounters.

- \textit{Medical Record Number (MRN),\textsuperscript{6} required but may be empty}. This is a unique number
  assigned to patient’s medical record, maintained by the healthcare facility’s information
  system.

- \textit{Episode of Care\textsuperscript{7} Number, required but may be empty}. A unique number assigned to
  patient’s records associated with the continuous period of care related to a clinical
  problem. Episode of care may include several visits/encounters over a period; care may
  be provided at various facilities/specialists within the institution or outside of the
  institution. Important for quality and population health use cases.

- \textit{Pre-Visit Number, required but may be empty}. A unique number assigned when
  scheduling patient’s individual visit /encounter at the healthcare facility.

\textbf{PID-5 – Patient Name (XPN), required}. This field contains one or more names for the patient.

\textbf{Note 2}: At least one name must be provided, with at least the first and second subfields “Family
Name” and “Given Name” valued. See the constrained profile definition of data type XPN in
Table 4.1.1.1-2 below. \textbf{Please note that red text in the Usage column indicates a constraint
on the ITI PAM Profile specification.}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|c|}
\hline
SEQ & LEN & DT & USAGE & CARD & TBL# & COMPONENT NAME \\
\hline
1 & 194 & FN & R & [0..1] & & Family Name \\
2 & 30 & ST & RE & [0..1] & & Given Name \\
\hline
\end{tabular}
\caption{Table 4.1.1.1-2: XPN Data Type – extended person name}
\end{table}

\textsuperscript{4} National Institute of Standards and Technology (NIST). Digital Identity Guidelines. Special Publication 800-63-3.

\textsuperscript{5} American Health Information Management Association (AHIMA). Pocket Glossary of Health Information
repositories of information from overlapping patient populations that are maintained in separate systems and
databases”

\textsuperscript{6} American Health Information Management Association (AHIMA). Pocket Glossary of Health Information
Management and Technology. Chicago, IL. 2014. p.70: “A unique numeric or alphanumeric identifier assigned to
each patient’s record upon admission to a healthcare facility”

\textsuperscript{7} American Health Information Management Association (AHIMA). Pocket Glossary of Health Information
by healthcare professionals in relation to a particular clinical problem or situation”
SEQ   LEN   DT   USAGE   CARD   TBL#   COMPONENT NAME
3     30    ST   O      [0..1]  Second and Further Given Names or Initials Thereof
4     20    ST   O      [0..1]  Suffix
5     20    ST   O      [0..1]  Prefix
6     6     IS   X      [0..0]  (See Note1)  0360  Degree
7     1     ID   R      [1..1]  0200  Name Type Code
8     1     ID   O      [0..1]  0465  Name Representation Code
9     483   CE   O      [0..1]  0448  Name Context
10    53    DR   X      [0..0]  (See Note1)  Name Validity Range
11    1     ID   O      [0..1]  0444  Name Assembly Order
12    26    TS   O      [0..1]  0414  Effective Date
13    26    TS   O      [0..1]  0414  Expiration Date
14    199   ST   O      [0..1]  Professional Suffix

Note 1: In accordance with the HL7 Version 2.5.1 usage of this data type, “Degree” and “Name Validity Range” are provided here for completeness, but must not be used.

Additional Requirements:

- **Family Name, required.** Do not send prefix or suffix in the family name field. Capture in the format shown in the documents verifying the patient’s identity. NOTE: If the patient does not have a Given Name, their single name will be sent in **Family Name.** E.g., Lightfeather, or Cher.

- **Given Name, required but may be empty.** Separate data entry. Capture in the format shown in the documents verifying the patient’s identity. NOTE: If the patient does not have a Given Name, his single name will be sent in **Family Name.** E.g., Lightfeather, or Cher.

- **Second and Further Given Names or Initials Thereof, optional.** Separate data entry. Capture in the format shown in the documents verifying the patient’s identity.

- **Suffix, optional.** Separate entry. Do not send in the Given Name field. Capture in the format shown in the documents verifying the patient’s identity. The Weber State University Data Standards, and Middlebury Library & ITS Wiki Name Standards are two recommended sources for corresponding code sets.

- **Prefix, optional.** Separate entry. Do not send prefix in the Family Name field. Capture in the format shown in the documents verifying the patient’s identity. The Weber State University Data Standards. URL: [http://departments.weber.edu/qsupport&training/Data_Standards/Name.htm](http://departments.weber.edu/qsupport&training/Data_Standards/Name.htm)

- **Middlebury Library & ITS Wiki: Name Standards. URL: [https://mediawiki.middlebury.edu/wiki/LIS/Name_Standards](https://mediawiki.middlebury.edu/wiki/LIS/Name_Standards)
University Data Standards\(^1^1\), and Middlebury Library &ITS Wiki Name Standards \(^1^2\) are
two recommended sources for corresponding codesets.

- Patient may also provide a preferred patient name, which must also follow the above
guidelines.

**PID-6 – Mother’s Maiden Name (XPN), conditional:** Condition predicate.

**Note 3:** This field is required if known. It serves to help link records when other demographic
data and search criteria are not the same.

**PID-7 – Date/Time of Birth (TS), required.**

**Note 4:** Date of Birth\(^1^3\) format is Year, Month, Day. If the exact date of birth is not known, it can
be truncated to the year of birth (e.g., 1954), or to the year and month of birth (e.g., 1954,11).
Time may be provided for newborns only.

**PID-8 – Administrative Sex (IS), required.**

**Note 5:** The authorized values are shown in Table 4.1.1.1-3.

<table>
<thead>
<tr>
<th>Table 4.1.1.1-3: Administrative Sex Values</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Value</strong></td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>F</td>
</tr>
<tr>
<td>M</td>
</tr>
<tr>
<td>O</td>
</tr>
<tr>
<td>U</td>
</tr>
<tr>
<td>A</td>
</tr>
<tr>
<td>N</td>
</tr>
</tbody>
</table>

**PID-10 – Race (CE), required.**

**Note 6:** The authorized values are shown in the user-defined Race Values Table 4.1.1.1-4.

<table>
<thead>
<tr>
<th>Table 4.1.1.1-4: Race Values</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Value</strong></td>
</tr>
<tr>
<td>AI</td>
</tr>
<tr>
<td>AN</td>
</tr>
<tr>
<td>A</td>
</tr>
<tr>
<td>AA</td>
</tr>
<tr>
<td>NH</td>
</tr>
</tbody>
</table>

\(^{1^1}\) Weber State University Data Standards. URL:
http://departments.weber.edu/qsupport&training/Data_Standards/Name.htm

\(^{1^2}\) Middlebury Library &ITS Wiki: Name Standards. URL: https://mediawiki.middlebury.edu/wiki/LIS/Name_Standards

\(^{1^3}\) ISO 8601 Numeric Date and Time format. URL: https://www.iso.org/iso-8601-date-and-time-format.html
PID-11 – Patient Address (XAD), required.

Note 7: This field contains one or more addresses for the patient. At least one address must be provided, with at least the “Street Address”, “City”, “State”, and “Zip or Postal Code” subfields valued. See the constrained profile definition of data type XAD in Table 4.1.1.1-5 below. Please note that red text in the Usage column indicates a constraint on the ITI PAM Profile specification.

Table 4.1.1.1-5: XAD Data Type – extended address

<table>
<thead>
<tr>
<th>SEQ</th>
<th>LEN</th>
<th>DT</th>
<th>USAGE</th>
<th>CARD</th>
<th>TBL#</th>
<th>COMPONENT NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SAD</td>
<td>R</td>
<td>[1..*]</td>
<td></td>
<td></td>
<td>Street Address</td>
</tr>
<tr>
<td>2</td>
<td>120</td>
<td>ST</td>
<td>O</td>
<td>[0..*]</td>
<td></td>
<td>Other Designation</td>
</tr>
<tr>
<td>3</td>
<td>50</td>
<td>ST</td>
<td>R</td>
<td>[1..1]</td>
<td></td>
<td>City</td>
</tr>
<tr>
<td>4</td>
<td>50</td>
<td>ST</td>
<td>R</td>
<td>[0..1]</td>
<td></td>
<td>State</td>
</tr>
<tr>
<td>5</td>
<td>12</td>
<td>ST</td>
<td>R</td>
<td>[0..1]</td>
<td></td>
<td>Zipcode or Postal Code</td>
</tr>
<tr>
<td>6</td>
<td>3</td>
<td>ID</td>
<td>O</td>
<td>[1..1]</td>
<td>0399</td>
<td>Country</td>
</tr>
<tr>
<td>7</td>
<td>3</td>
<td>ID</td>
<td>R</td>
<td>[1..1]</td>
<td>0190</td>
<td>Address Type</td>
</tr>
<tr>
<td>8</td>
<td>ST</td>
<td>O</td>
<td>[0..*]</td>
<td></td>
<td></td>
<td>Other Geographic Designation</td>
</tr>
<tr>
<td>9</td>
<td>IS</td>
<td>O</td>
<td>[0..1]</td>
<td></td>
<td></td>
<td>County/Parish Code</td>
</tr>
<tr>
<td>10</td>
<td>IS</td>
<td>O</td>
<td>[0..1]</td>
<td></td>
<td></td>
<td>Census Tract</td>
</tr>
<tr>
<td>11</td>
<td>ID</td>
<td>O</td>
<td>[0..1]</td>
<td></td>
<td></td>
<td>Address Representation Code</td>
</tr>
</tbody>
</table>

Additional Requirements:

- **Street Address, required.** Post Office Box Number can be used for street address.
- **Address Type, required.** Use the HL7 Address Types Table 0190. For the primary address, use the constrained values in Table 4.1.1.1-6 below.
- **Address subfields, required.** Capture in the format shown in the documents verifying the patient’s address, based on US Postal Standard

- **Country, required.** All uppercase. Use HL7 Country Code table 0399.

---

Table 4.1.1.1-6: Address Types – Primary Address

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Current</td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>Temporary Home</td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>Legal Address</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>Mailing</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Permanent</td>
<td></td>
</tr>
</tbody>
</table>

**PID-13 – Phone Number – Home (XTN), required but may be empty.**

Note 8: This field is required if known. This field contains one or more contact methods for the patient. It serves to help locate records when other demographic data and search criteria are not exactly the same. See the constrained profile definition of data type XTN in Table 4.1.1.1-7 below. **Please note that red text in the Usage column indicates a constraint on the ITI PAM Profile specification.**

Table 4.1.1.1-7: XTN Data Type – extended telecommunication number

<table>
<thead>
<tr>
<th>SEQ</th>
<th>LEN</th>
<th>DT</th>
<th>USAGE</th>
<th>CARD</th>
<th>TBL#</th>
<th>COMPONENT NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>199</td>
<td>TN</td>
<td>RE</td>
<td>[0..1]</td>
<td></td>
<td>Telephone Number</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>ID</td>
<td>C</td>
<td>[0..1]</td>
<td>0185</td>
<td>Telecommunication Use Code</td>
</tr>
<tr>
<td>3</td>
<td>8</td>
<td>ID</td>
<td>O</td>
<td>[0..1]</td>
<td></td>
<td>Telecommunication Equipment Type</td>
</tr>
<tr>
<td>4</td>
<td>199</td>
<td>ST</td>
<td>O</td>
<td>[0..1]</td>
<td></td>
<td>Email Address</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>SNM</td>
<td>O</td>
<td>[0..1]</td>
<td></td>
<td>Country Code</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>SNM</td>
<td>O</td>
<td>[0..1]</td>
<td></td>
<td>Area/City Code</td>
</tr>
<tr>
<td>7</td>
<td>9</td>
<td>SNM</td>
<td>O</td>
<td>[0..1]</td>
<td></td>
<td>Phone Number</td>
</tr>
<tr>
<td>8</td>
<td>5</td>
<td>SNM</td>
<td>O</td>
<td>[0..1]</td>
<td></td>
<td>Extension</td>
</tr>
<tr>
<td>9</td>
<td>5</td>
<td>ST</td>
<td>O</td>
<td>[0..1]</td>
<td></td>
<td>Any Text</td>
</tr>
</tbody>
</table>

Note: A change proposal has been submitted to ITI - CP#977 for XTN datatype clarification for phone number. This change proposal may affect the datatypes shown above in this table.

Additional Requirements:

- **Telecommunication Use Code, conditional.** Must provide preferred method of contact code from Table 4.1.1.1-8 if telephone number is available. See the values from HL7 Table 0185 Preferred Method of Contact below.

Table 4.1.1.1-8: Preferred Method of Contact Values

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Beeper Number</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Cellular Phone Number</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>E-mail Address</td>
<td></td>
</tr>
</tbody>
</table>
### Value Description Comment

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>Fax Number</td>
</tr>
<tr>
<td>H</td>
<td>Home Phone Number</td>
</tr>
<tr>
<td>O</td>
<td>Office Phone Number</td>
</tr>
</tbody>
</table>

**PID-14 – Phone Number - Business (XTN), required but may be empty.**

*Note 9:* This field is required if known. It serves to help locate records when other demographic data and search criteria are not exactly the same. Follow same guidelines as for Home Phone Number above.

**PID-15 – Primary Language (CE), required.**

*Note 10:* Use HL7 Language table 0296.

**PID-18 – Patient Account Number (CX), required but may be empty.**

*Note 11:* HL7 Definition: This field contains the patient account number assigned by accounting to which all charges, payments, etc., are recorded. It is used to identify the patient’s account. Relationship to encounter: A patient account can span more than one enterprise encounter.

Condition predicate: At least one of the fields PID-18 “Patient Account Number” or PV1-19 “Visit Number” shall be valued in the messages of transaction [ITI-31] that use the PV1 segment. Patient Visit Number should be entered here and not in PID-3 above.

This is the same as the AHIMA definition of the Patient’s Visit/Encounter Number:

*Visit/Encounter*[^15] **Number (account number), required but may be empty.** A unique number assigned to patient’s individual visit/encounter at the healthcare facility with unique start and end time; may be a part of a series of visits within the episode of care.

**PID-22 – Ethnic Group (CE), required.**

*Note 12:* Use User-defined Table 4.1.1.1-9 below, extended from the HL7 Ethnic Group table 0189.

Table 4.1.1.1-9: Ethnic Group Values

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>Hispanic or Latino</td>
</tr>
<tr>
<td>NH</td>
<td>Not Hispanic</td>
</tr>
<tr>
<td>U</td>
<td>Unknown</td>
</tr>
<tr>
<td>PD</td>
<td>Patient Declined to Answer</td>
</tr>
</tbody>
</table>

[^15]: American Health Information Management Association (AHIMA). Pocket Glossary of Health Information Management and Technology. Chicago, IL. 2014. p.151: “A single encounter with a healthcare professional that includes all the services supplied within the encounter”