REGISTRATION QA - DAILY CHECKLIST

Employee Name:	_____	Reviewer Initials:	_____
Registration Date:	_____	Review Date:	_____
Patient Account No	_____	Total Errors:	_____

Reviewer to check the following items from one or more of the below listed source documents:

a) Copy of insurance card & patient ID
b) Copy of insurance eligibility response
c) MSP Questionnaire
d) Copy of physician orders

Patient Information:	**Error**	**Guarantor Information:**	**Error:**
Patient Name Format	☐	Guarantor Relationship to Patient	☐
Patient Address	☐	Guarantor Name	☐
Patient Phone #	☐	Guarantor Address	☐
Patient SSN	☐	Guarantor Phone #	☐
Patient DOB	☐	Guarantor SSN	☐
Emergency Contact	☐	Guarantor DOB	☐
Patient Employer	☐	Guarantor Employer	☐
Employer Address	☐	Employer Address	☐
Employer Phone #	☐	Employer Phone #	☐
Patient MRN	☐	Minor Listed as Guarantor	☐
Insurance Information	**Error**	**Other Information**	**Error:**
Insurance Co Name	☐	Incomplete/Incorrect MSP	☐
Insurance Policy/Group#	☐	Medical Necessity Checked/ABN	☐
Subscriber Name	☐	Accident Code/Date & Time	☐
Subscriber DOB	☐	Coverage/BenefitsVerified	☐
Subscriber Relationship to Pt ?	☐	Incorrect Insurance Placement	☐
PreCert Required	☐	M'care & M'care HMO loaded	☐

Source: AccuReg. Used with permission.