Document Name	Cerner Note Type	Notes
Billing and Insurance Documents		
Advance Beneficiary Notice (ABN)	Advance Beneficiary Notice	
Balance Billing Acknowledgement - Out-Of-Network Health Plans	Billing Authorization	Under the subject field when identifying the document plaese label "Balance Billing Acknowledgement DOS 00/00/0000"
Good Faith Estimate For Health Care Items and Services	Billing Authorization	Under the subject field when identifying the document please label "Good Faith Estimate DOS 00/00/0000"
Insurance Authorization	Billing Authorization	
Notice of Non-Covered Services	Advance Beneficiary Notice	
Worker's Comp Paperwork	Work Comp/Injury Document	Medical Necessity, Demographics, Physician's Report
Documents Not Scanned Into the Patient's Chart		
After the Shots…Medicines and Dosages to Reduce Pain and Fever	NOT Scanned to Patient Chart	These are for the patient only. The fact that instructions were provided will be captured in the clinic notes.
Death Certificate	NOT Scanned to Patient Chart	Review for information needed, make notes and return document to patient/guardian. These are owned by the State of MI and not ours to release. Or if our provider signs off the Death Certificate, just send to the state.
Down Time New Patient Registration Form	NOT Scanned to Patient Chart	Shred after entering into system.
Enrollment forms: Medicaid, Disability, etc.	NOT Scanned to Patient Chart	Send to CBO or billing office for financial use.
Financial Assistance Application	NOT Scanned to Patient Chart	Send to CBO or billing office for financial use.
Financial Assistance Questionnaire	NOT Scanned to Patient Chart	Send to CBO or billing office for financial use.
Heart Deciding to have a Transcatheter AV Replacement THV S	NOT Scanned to Patient Chart	These are for the patient only. The fact that instructions were provided will be captured in the clinic notes.
Heart Going Home After Transcatheter Heart Valve Replacement THV S	NOT Scanned to Patient Chart	These are for the patient only. The fact that instructions were provided will be captured in the clinic notes.
Home Care or Hospice Notice of death	NOT Scanned to Patient Chart	Check PowerChart to verify patient is marked as expired and the date of death is entered.
Immunization Records	NOT Scanned to Patient Chart	When receiving notice of an immunization/vaccine from an outside source, enter into PowerChart as per the Job Aid and then shred. Do NOT scan.
MAPS Report	NOT Scanned to Patient Chart	DO NOT SCAN - per state rules we cannot maintain, only for review. The scores can be captured in Cerner. The actual printed report must be shredded.
Marriage Certificate	NOT Scanned to Patient Chart	Review for information needed, make notes and return document to patient/guardian. These are owned by the State of MI and not ours to release.
Medical Necessary Diagnosis from Munson Medical Center	NOT Scanned to Patient Chart	Return to MMC
Medicare Secondary Payer Patient Questionnaire	NOT Scanned to Patient Chart	Send to CBO or billing office for financial use.

Document Name	Cerner Note Type	Notes
Munson Home Health - Home Medical Equipment Consent to Service	NOT Scanned to Patient Chart	Provider signs, then send to Munson Home Health Care (or other home health agency), as this is their form.
New Patient Application	NOT Scanned to Patient Chart	Once data is entered, shred the application.
Non Participating Insurance / Out of Network	NOT Scanned to Patient Chart	Send to CBO or billing office for financial use
Opioid Information Sheet	NOT Scanned to Patient Chart	This is for the patient to take home
Patient Registration Form	NOT Scanned to Patient Chart	This is abstracted into the system, then shred when done.
Physician Query Form	NOT Scanned to Patient Chart	Return to the facility. They will manage the scanning and maintenance.
Pictures - From Cerner MHC hospitals	NOT Scanned to Patient Chart	Pictures would have been incorporated into record.
Plain Language Summary	NOT Scanned to Patient Chart	
Plain Language Summary - Spanish	NOT Scanned to Patient Chart	
Power of Attorney (General/Financial) DPOA	NOT Scanned to Patient Chart	Send to CBO or billing office for financial use. Note: For DPOAH (Medical) see above.
Preparation for Colonoscopy	NOT Scanned to Patient Chart	These are for the patient only. The fact that instructions were provided will be captured in the clinic notes.
Preparing for Your Surgery	NOT Scanned to Patient Chart	These are for the patient only. The fact that instructions were provided will be captured in the clinic notes.
Prostate Biopsy Post Instruction	NOT Scanned to Patient Chart	These are for the patient only. The fact that instructions were provided will be captured in the clinic notes.
Record Releases "From"	NOT Scanned to Patient Chart	Not scanned into Cerner; instead this information is scanned to RecordConnectPro.
Request for Census Adjustment/Clarification MMC	NOT Scanned to Patient Chart	This is only department to department communication.
Requirements for Sending Radiology Studies to MMC	NOT Scanned to Patient Chart	This is only department to department communication.
Short Case Stay Summary	NOT Scanned to Patient Chart	Used by Grayling Hospital. This will be in PowerChart.
Stress Test Worksheet THV	NOT Scanned to Patient Chart	
Subrogation Questionnaire	NOT Scanned to Patient Chart	Return to the patient.
Surgery Scheduling Form	NOT Scanned to Patient Chart	BAU form this is communicate between two offices which does not need to be scanned.
Urodynamic Protocol - Adult	NOT Scanned to Patient Chart	
Wave Test Results	NOT Scanned to Patient Chart	This is a Cadillac Primary Care form. The results of this are entered into a Cerner Powerform. Do not need to scan this worksheet.
Welcome to Munson Physician Network	NOT Scanned to Patient Chart	
Welcome to our Practice - Surgical Services	NOT Scanned to Patient Chart	
Documents Provided by the Patient		
5 Wishes	AMD/DPOAH	Compare to checklist to see if document is valid for scanning. If not, forward to the Advance Care Planning Team. Generally, the 5 wishes is no longer a valid document in the state of MI.
Advanced (Medical) Directive / Power of Attorney (Medical) / DPOAH (Medical)	AMD/DPOAH	Also known as: Living Will, or Power of Attorney Healthcare DPOAH Note: DPOA (General/Financial) see below.

Document Name	Cerner Note Type	Notes
Behavioral Health Assessments - SCARED, Vanderbilt	Behavioral Health Form	Screenings from teacher at schools, Conner screening. Patient and parent can fill out. Child abilities at school and the parents view.
Behavioral Health forms Provided by Patient	Behavioral Health Form	
Capacity Assessment	Capacity Assessment	Encounter level
CDL Card (generally with the packet)	Other Documentation	Patient Generated
DNR (Do Not Resuscitate) part of DPOAH or Advance Directives	AMD/DPOAH	If the ACP documents contain a DNR/POLST, break apart and scan as two separate documents under the applicable headings.
Emergency Treatment Auth	Emergency Treatment Auth	
Emergency Treatment For Minor/Limited POA	Emergency Treatment Auth	
Implant information	Implant Record	Information should be recorded on the Implant section on the Histories tab in the TOC.
Letter of Guardianship	Letter of Guardianship	Patient level
Medication List (from patient)	Patient Provided Medication List	e.g. Know Your Medications
Mi-POLST	POST/DNR	
Patient Diary or Logbook (blood glucose, blood pressure, daily weight, food, voiding, etc.)	Notes Authored by Patient	Describe in Subject (e.g. Blood Pressure Log), this includes Apple Watch and Kardia data.
Safety Agreement	Behavioral Health Form	Send to the last provider who saw the patient.
Outside Documents		Documents from a patient care facility that is not a Phase 1 Munson Cerner site, or one of the 5 primary hospital sites.
Audiology Hearing Tests	Outside Record	Subject should indicate "Hearing Test"
Behavioral health	Outside Behavioral Health	
Cardiac Rehab Documents	Outside Record	
Cardiology	Outside Cardiac Diagnostic	Electrophysiology, echos, holter data and event recorder, ECGs THV scans tests
Consultation Report	Outside Consultation Note	Include specialty doing the consult in the Subject (e.g. Cardiology Consult)
Cowell Family Cancer Center INFUSION TREATMENT NOTE	Outside Record	Outside consultation or office note.
Dept of Human Services forms (MIHP)	Outside Record	Maternal Infant Health Program (MIHP) documentation, including evals and discharge summary.
EEG	Outside Record	
ER Report	Outside Emergency Department Report	
ESWL Treatment Record (Copper Ridge)	Outside Operative/Procedure Report	
Fax Cover and Transmittal Sheets	Do Not Separately Scan	Keep as part of the entire fax/transmittal, not a stand alone document.
Fertility Center Correspondence	Outside Record	Add to the subject line "Fertility Center"
History and Physical	Outside History and Physical	
Home Oxygen evaluation/qualification	Outside Record	
Hospital Summary	Outside Hospital Summary	
Interstim Therapy Trial Assessment	Outside Record	

Document Name	Cerner Note Type	Notes
Lab ordered in-office, resulted directly from an outside source	Send Out Lab Report	FIT, Cologaurd Results, FNA Results, Cytology, Gene Type testing, State Lab STI Testing (e.g. Quest Diagnostics)
Letters from other Clinic/Providers	Outside Record	
Letters from Patient	Notes Authored By Patient	Letters / fax / other mailings
Long-term Care Notes	Outside Long Term Care Note	
MDCH HIV Results	Send Out HIV Report	
Newborn Paperwork from CAD and GRY Hospital	Outside Record	Documents from CAD and Grayling as they use a separate app for their newborn records.
Nexus Statement VA	Other Documentation	Statement/letter which connects the vets in-service event to the current medical condition
Office Notes	Outside Office Note	
Operative/Procedure Reports	Outside Operative/Procedure Report	Include procedure name in the Subject. (Colonoscopy Report, EGD Report, Operative Procedure, etc.)
Outside Lab or Pathology Report	Outside Lab/Pathology Report	e.g.: Aegis, Alere Home INR Monitoring, Biopsy Pathology
Outside Urgent Care Report	Outside Record	
Pacemaker Diagnostic Recordings (Biotronik/St. Jude)	Outside Cardiac Diagnostic	Pacemaker/ICD check. (e.g. Boston Scientific, St. Jude)
Physician Ownership Disclosure Form Regarding Copper Ridge Surgery Center	Other Documentation	
Pulmonary Function Test	Pulmonary Function Image	Check to see if performed in MHC and already scanned to that specific date of service.
Radiology Reports	Outside Radiology Report	
Paper Documents Generated in the Office		
Affidavit for Specimen & Requisition with Wrong Identifier Information	Other Documentation	Mismatched identifiers on lab specimens to confirm same patient
Alpha-Fetoprotein (AFP) Quad/Screen Second Trimester Maternal Screening	Assessment Note	
Animal Bite Exposure Report (communicable diseases)	Other Documentation	
Assessments for Early Childhood, School, Sports, Work or Governmental Entities	Assessment Note	Head Start, Camp Physical, Sports Physical, Medical Passport, Medical Needs MI-DHS, School Medication Administration Authorization; Sheriff's Office Request/Refusal Slip For Medical Care; Medical Clearance Request-Child Care Licensing; Medical Statement for Foster Care Licensing; Reasonable Accom/Modification Request from HUD.
Authorization for Treatment and Medical Release / Notice of Privacy Practice	Consent for Treatment	Use date signed when scanning. Make sure patient has signed and dated correctly, scan front and back.
BCCCP Screening Form	Billing Authorization	
Bladder Health Questionnaire	Other Patient Questionnaire	
Certificate of Terminal Illness	Certificate of Terminal Illness	Should be signed and completed PRIOR to scanning.
Consent for Treatment or Procedure	Consent for Treatment	Invasive, Diagnostic and therapeutic Procedures, i.e. Colonoscopy, Stress Test, EGD

Document Name	Cerner Note Type	Notes
Consult Request Form / Referral out	Other Documentation	
Controlled Substance Agreement	Controlled Substance Agreement	Date the document was signed.
CWTA Reduced Public Bus Fare Application	Other Documentation	Disability parking
DHD#10 Animal Bite/Exposure Report	Other Documentation	
Diagnosis Clarification Request	Documentation Query	Provider signs
Disability Form	Other Documentation	e.g. Establishing long or short term disability and or continuation.
Disability Parking Placard Application	Other Documentation	
Documentation Medical necessity Query	Documentation Query	Certificate of medical necessity; queries for diagnosis code changes on labs, oxygen, DME, etc.
ECG Tracings (in clinic)	ECG Image	
EEG	Electroencephalogram (EEG)	
EMG	Electromyography Report (EMG)	
Equipment Waiver THV	Other Documentation	
FMLA Forms	Other Documentation	If our provider approving, make sure all areas requiring signature and date are complete BEFORE scanning.
Foot Exam Forms - Meridian DM	Assessment Note	Quality Forms
Group Visit Agreements	Other Consent	
Handicap Sticker Form	Other Documentation	
Health Appraisal (HRA for Insurance)	Other Documentation	Use the Subject Line to add the name of the Insurance, example: "Priority Health HRA".
Health History	Health History Questionnaire	General or Comprehensive Patient Medical History
Health Screening and Assessment Forms	Assessment Note	Social determinants of health, new patient screening, VOMS, preadmission screenings (PAS), annual resident review (APR), immunization visit forms
HIPAA Privacy Information	HIPAA Privacy Document	Minor Release Statement and Form, Parental/Patient Consent Form
Immunization Screening	Flowsheet/Checklist	
Implant information	Implant Record	Information should be recorded on the Implant section on the Histories tab in the TOC
In Office Medication & Immunization Administration Downtime Form	Medication Administration Record	Should be back-charted once system is back online.
Insurance Related Health Assessment Forms	Other Documentation	Payer specific health assessment forms.
Insurance Related Physician or PCP Selection or Change Forms	Other Documentation	To identify physician selection with payer or to change the PCP (including Medicaid MCO plans).
Interventional/Bedside Procedural Safety Checklist	Flowsheet/Checklist	
Intravenous Iron Order - Outpatient ADULT	Order Requisition	
Mail Returned	Other Documentation	Subject to include, "Returned Mail" and a description of what was returned.
Medical Examiners Certifications (Death Certificate)	Record of Death	Will need to validate that the patient is flagged as "Deceased" in RevCycle.

Document Name	Cerner Note Type	Notes
Mental Cognitive Assessments	Assessment Note	Mini cogs, mini-mental state exam, Mental Illness/Intellectual Disability/Related Condition Exemption Criteria Certification Level II Screening.
Miscellaneous Patient Questionnaire	Other Patient Questionnaire	A focused patient questionnaire, e.g. TB skin testing, MRI
MURJ Pacemaker/Device Check	Procedure/Treatment Note	Only pacemaker/device check downloaded from MURJ system at THV.
Office Policies Consent/Agreement	Other Consent	Scan either to the first visit or to a non billable phone message.
Opioids: Start Talking Consent for Controlled Substances Containing Opioids	Controlled Substance Agreement	If prescribing to a minor, the provider MUST sign the form (date the document was signed is important).
Order Requisition	Order Requisition	Clarification or Entry of a new Order into the EHR, copies of a paper order that are placed during the encounter, e.g. Certification of Hospice, DME, etc.
Paper Education Handout	Ambulatory Patient Education	Not the same as information in Cerner that may be printed. Pieces of paper handed to the patients. Examples: Correcting Blood Sugar Levels with Insulin, Post Vasectomy Semen Analysis Instructions.
Peak Flow Tracking Chart	Flowsheet/Checklist	
Physician Office Guidelines and Procedures Agreement	Other Documentation	
Prostate Biopsy Checklist	Flowsheet/Checklist	
Record Releases "To"	Release of Information	
Refusal to Consent	Other Consent	e.g. Vaccination Refusal
Report Child or Elder Abuse	Protective Services Report	
Rhythm Strips	Cardiac Monitoring Wave Form	
Screening Checklist for Contraindications to Vaccines for Children and Teens	Flowsheet/Checklist	
Transportation/Driving Assessments	Assessment Note	Medical verification for transportation, driver assessment form
United Healthcare Medical Record Clarification	Other Documentation	This should already be signed by the provider.
Urodynamics Testing and Assessment	Urology Office Procedure	
		Revised 11.7.2023 JAS