MEDICAL EXPENDITURE PANEL SURVEY
MEDICAL PROVIDER COMPONENT
EVENT FORM

FOR
PHARMACIES
FOR
REFERENCE YEAR 2021

OMB

(Public reporting burden for this collection of information is estimated to average 3 minutes per response, the estimated time required to complete the survey. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-0118) AHRQ, 5600 Fishers Lane, Rockville, MD 20857.)

DCS: READ THIS ALOUD ONLY IF REQUESTED BY RESPONDENT.

PRESS NEXT TO CONTINUE IN THIS EVENT FORM

PRESS BREAKOFF TO DISCONTINUE

DATE FILLED

Q1. Date Filled Month:_____Day:_____Year:_____

DK/REF – CONTINUE TO Q2

PRESCRIPTION INFORMATION

Q2. Prescription information will be identified using:

NOTE: TRY TO OBTAIN NDC. USE DRUG NAME ONLY IF NDC NOT AVAILABLE.

1= NDC

2 = Drug Name, Strength/Unit, and Dosage Form

[IF Prescription Information = 1 (NDC), GO TO Q2a;
IF Prescription Information = 2 (Drug Name, Strength/Unit, & Dosage Form), GO TO Q2b]

Q2a. NDC

ENTER 11-DIGIT NDC WITHOUT DASHES OR SPACES.

NDC IS UNKNOWN OR REFUSED, RETURN TO PREVIOUS SCREEN AND SELECT **DRUG NAME** OPTION

_____

When Q2a is COMPLETE, GO TO Q3a/QTY

Q2b. Drug Name:

Q2b_1:

Compound drug? _____

Durable Medical Equipment: _____ DME_1

IF DURABLE MEDICAL EQUIPMENT GO TOQ3A***

MJ?_____MJ_1

IF MJ GO TO Q3a***

When Drug Name is complete, send user to Q2c/STRENGTH

Q2c. Strength

_____

Q2d. Unit:

_____

Q2c2. Strength 2:

_____

Q2d2. Unit 2:

_____

Q2e. Dosage Form:

_____

After Q2e, CONTINUE TO Q3a/b.
Q2b - DK/REF – CONTINUE TOQ2c/d
Q2c/d - DK/REF – CONTINUE TO Q2e
Q2e - DK/REF – CONTINUE TOQ3a/b

QUANTITY

Q3a. Quantity:

_____

Q3b. Unit:

_____

Q3b – DK/REF – CONTINUE TO Q4

Q4. How many days were supplied?

IF PRESCRIPTION WAS TO BE USED "AS NEEDED" ENTER 999

_____

Q4 – DK/REF – CONTINUE TO Q5

PAYMENT INFORMATION

Q5. Patient Payment:

$_____.____

Q5a. Were there any 3rd party payers?

YES

NO

Q6. Type of 3rd Party Payer

_____

Q7. 3rd Party Payment

$_____. _____

NOTE: IF PATIENT PAYMENT WAS $1 OR LESS, EXPECT THE 3rd PARTY PAYER TO BE A PUBLIC PROGRAM, E.G., MEDICAID OR OTHER STATE/LOCAL GOVT, ETC.

Any more 3rd Party Payers?

1. Yes
2. No

Q6/Q7 - ALLOW A MAXIMUM OF TWO 3rd PARTY PAYERS. IF USER SAYS "YES, MORE" THREE TIMES THEN THE PROGRAM WILL GO TO FINISH SCREEN.

Q5 - DK/REF – CONTINUE TO Q5a.
Q5a - DK/REF – CONTINUE TO EXIT SCREEN.
Q6 - DK/REF – CONTINUE TO Q7.
Q7 - DK/REF – CONTINUE TO EXIT SCREEN.

FINISH SCREEN

PRESS VALIDATE TO COMPLETE THIS EVENT FORM.