



**US Public Health Service
2007 Pharmacy Component**

Patient Name:	Pharmacy:
Patient ID:	Pharmacy ID:

Data Form

A Part of the Medical Expenditure Panel Survey (MEPS)

	Date Filled	NDC						Drug Name				Strength	Unit
	/ /07							-					

Quantity	Quantity Unit	Dosage Form	Patient Payment	Type of 3rd Party Payer			3rd Party Payment
			\$____.____				\$____.____

	Date Filled	NDC						Drug Name				Strength	Unit
	/ /07							-					

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			\$____.____				\$____.____

	Date Filled	NDC						Drug Name				Strength	Unit
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	Date Filled	NDC						Drug Name				Strength	Unit
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			\$____.____				\$____.____