Form Approved
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MEDICAL EXPENDITURE PANEL SURVEY
MEDICAL PROVIDER COMPONENT
DATA FORM
FOR
PHARMACIES
FOR
REFERENCE YEAR 2011

OMB

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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:_____

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 R_RXIDTYPE = 1 (NDC), GO TO Q2a;
IF R_RXIDTYPE = 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

_____

Q2b. Drug Name:

_____

Q2c. Strength

WHEN RECORDING STRENGTH, ENTER A WHOLE NUMBER OR A FRACTIONAL VALUE UP TO 3 DECIMAL POINTS. VALID ENTRIES INCLUDE 15, 3.5, 2.25, 0.333

_____

Q2d. Unit:

_____

Note: WHERE NECESSARY, YOU MAY ENTER A SECOND STRENGTH AND UNIT FOR EXAMPLE TO DESCRIBE A SOLUTION OR CONCENTRATION (e.g., 7 mg/5 ml). OTHERWISE SKIP TO Q2e DOSAGE FORM

Q2c2. Strength

_____

Q2d2. Unit:

_____

Q2e. Dosage Form:

_____

QUANTITY

Q3a. Quantity:

_____

WHEN RECORDING QUANTITY, ENTER A WHOLE NUMBER OR A FRACTIONAL VALUE UP TO 3 DECIMAL POINTS. VALID ENTRIES INCLUDE 100, 15, 3.5, 2.25, 0.333

NOTE 1: QUANTITY SHOULD REFLECT THE *CONTENTS* OF A CONTAINER, NOT THE NUMBER OF CONTAINERS.
EXCEPTION: IF NDC PROVIDED, THEN *NUMBER* OF EPIPENS CAN BE RECORDED FOR QUANTITY, AS OPPOSED TO QUANTITY OF EPIPEN CONTENTS.

NOTE 2: FOR A DEVICE, ACCEPT A QUANTITY OF 1 OR 2.

NOTE 3: FOR PILLS, A QUANTITY OF 1 OR 2 IS ACCEPTABLE BUT CONSIDER EXCEPTION BELOW BEFORE ENTRY.
EXCEPTION: IF IT APPEARS THE QUANTITY IS FOR ONE OR TWO DOSEPAKS CONTAINING MULTIPLE PILLS, THEN RECORD THE QUANTITY OF TABLETS, CAPSULES, ETC., THAT EACH DOSEPAK CONTAINS.

NOTE 4: FOR INHALERS, OINTMENTS, CREAMS, DROPS, LIQUID, FILLED SYRINGES (EXCEPT EPIPENS) AND OTHER DOSAGE FORMS NEEDING A QUANTITY UNIT, ASK FOR THE *QUANTITY* OF THE CONTENTS.

Q3b. Unit:

_____

Q4. How many days were supplied?

IF PRESCRIPTION WAS TO BE USED “AS NEEDED” ENTER 999

_____

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.

[ALLOW A MAXIMUM OF TWO 3rd PARTY PAYERS. IF USER SAYS “YES, MORE” THREE TIMES THEN THE PROGRAM WILL GO TO FINISH SCREEN.]

[If Q5a is DK/REF/RETRIEVABLE -- CONTINUE TO FINISH SCREEN.]

FINISH SCREEN

PRESS VALIDATE TO COMPLETE THIS EVENT FORM.