BOX_00
======

NOTE: THROUGHOUT THE CHARGE/PAYMENT (CP) SECTION, ENTRY OF ALL DOLLAR AMOUNTS WILL INCLUDE ONLY WHOLE DOLLARS. ENTRY OF CENTS WILL BE DISALLOWED.

IF EVENT TYPE IS HH AND HH PROVIDER ASSOCIATED WITH THE EVENT BEING ASKED ABOUT IS FLAGGED AS ‘AGENCY’ OR ‘INFORMAL’, GO TO BOX_26

IF EVENT TYPE IS MV AND MV01 IS CODED ‘2’ (TELEPHONE CALL) OR IF EVENT TYPE IS OP AND OP02 IS CODED ‘2’ (TELEPHONE CALL), GO TO BOX_26

OTHERWISE, CONTINUE WITH BOX_01

BOX_01
======

IF EVENT TYPE IS PM AND IS OM TYPE 2 OR 3, GO TO CP03

IF EVENT TYPE IS PM AND IS NOT OM TYPE 2 OR 3, CONTINUE WITH BOX_02

OTHERWISE, GO TO BOX_03

BOX_02
======

IF PERSON ALREADY FLAGGED AS 'NO CP INFORMATION FOR PM EVENTS NECESSARY' FOR THE CURRENT ROUND, GO TO BOX_26

IF PERSON ALREADY FLAGGED AS 'CP INFORMATION FOR PM EVENTS NECESSARY' FOR THE CURRENT ROUND, GO TO CP03

OTHERWISE, CONTINUE WITH CP01A

CP01A
=====

{PERSON'S FIRST MIDDLE AND LAST NAME} {STR-DT}

Other than (PERSON) (or anyone in the family), has there been any other source which made any payment towards (PERSON)'S prescription medicine since (START DATE)?

YES	1	
NO	2	{CP01}
REF	-7	{CP01}
DK	-8	{CP01}

PRESS F1 FOR DEFINITION OF SOURCE OF PAYMENT.

CP01B
=====

{PERSON'S FIRST MIDDLE AND LAST NAME} {STR-DT}

Who has been the usual source of payment for (PERSON)'s prescription medicines since (START DATE)?

TO TURN CHECK MARK ON/OFF, USE ARROW KEYS, PRESS ENTER.
TO ADD, PRESS CTRL/A. TO DELETE, PRESS CTRL/D.
TO LEAVE, PRESS ESC.

[1. Name of Source of Direct Payment-35]
[2. Name of Source of Direct Payment-35]
[3. Name of Source of Direct Payment-35]

PRESS F1 FOR DEFINITION OF SOURCE OF PAYMENT.

[Code One]

ROSTER DEFINITION: THIS ITEM DISPLAYS ALL SOURCES ON THE RU-SOURCES-OF-PAYMENT ROSTER. DO NOT INCLUDE PERSON/FAMILY ON ROSTER.

WRITE SOURCES SELECTED TO THE SOURCES-OF-PAYMENT ROSTER.

SOURCE ROSTER BEHAVIOR SPECIFICATIONS: 1. INTERVIEWER MAY SELECT ONLY ONE SOURCE ALREADY LISTED ON THE ROSTER. 2. INTERVIEWER SHOULD BE ABLE TO ADD ONLY ONE SOURCE AT THIS QUESTION. 3. INTERVIEWER SHOULD BE ABLE TO DELETE A SOURCE THAT WAS RECORDED ON THE SCREEN WHERE DELETE IS USED. THAT IS, AS LONG AS THE INTERVIEWER HAS NOT LEFT THE SCREEN, SHE SHOULD BE ABLE TO DELETE A SOURCE ENTERED IN ERROR. IF DELETE IS ATTEMPTED AT A TIME WHEN IT IS NOT ALLOWED, DISPLAY THE FOLLOWING ERROR MESSAGE: 'DELETE ALLOWED ONLY WHEN SOURCE IS FIRST ENTERED.'

CP01C
=====

{PERSON'S FIRST MIDDLE AND LAST NAME}

How much did (PERSON) pay out-of-pocket for (PERSON)'s last prescription?

IF AMOUNT PAID IS NOTHING, DK, OR REF, ENTER 1 FOR DOLLARS, THEN RESPONSE.

IS ANSWER IN DOLLARS OR PERCENT?

DOLLARS 1
PERCENT ..... 2 {CP01COV2}

[Code One]

CP01COV1
========

ENTER DOLLARS:

[Enter $ Amount] ..... {CP01}
REF ..... -7 {CP01}
DK ..... -8 {CP01}

| SOFT RANGE CHECK: $0 - $10,000 |

CP01COV2
========

ENTER PERCENT:

[Enter % Amount] .....
REF ..... -7
DK ..... -8

| SOFT RANGE CHECK: 1% - 100% |

CP01
====

{PERSON'S FIRST MIDDLE AND LAST NAME}

(Do/Does) (PERSON) (or someone in the family) send in a claim form to the insurance company for (PERSON)'s prescription medicines or does the pharmacy automatically do this for (PERSON)'s prescription medicines?

FAMILY SENDS IN CLAIM FORMS ..... 1 {CP03}
PHARMACY AUTOMATICALLY FILES CLAIM ..... 2 {BOX_26}
NOT EITHER TYPE OF SITUATION ..... 3 {BOX_26}
REF ..... -7 {CP03}
DK ..... -8 {CP03}

PRESS F1 FOR DEFINITIONS OF ANSWER CATEGORIES.

[Code One]

IF CODED '2' (PHARMACY AUTOMATICALLY FILES CLAIM), OR '3' (NOT EITHER TYPE OF SITUATION), FLAG THIS PERSON AS 'NO CP INFORMATION FOR PM EVENTS NECESSARY' FOR THE CURRENT ROUND.

IF CODED '1' (FAMILY SENDS IN CLAIM FORMS), '-7' (REFUSED), OR '-8' (DON'T KNOW), FLAG THIS PERSON AS 'CP INFORMATION FOR PM EVENTS NECESSARY' FOR THE CURRENT ROUND.

BOX_03
======

IF FIRST TIME THROUGH CHARGE PAYMENT FOR THIS PERSON-PROVIDER PAIR AND PAIR WAS FLAGGED AS 'COPAYMENT SITUATION' DURING THE PREVIOUS ROUND, CONTINUE WITH CP02

OTHERWISE, GO TO CP03

CP02
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

Before we talk about the charges for (PERSON)'S visit to (PROVIDER) on (VISIT DATE), let me take a moment to verify some information.

Last time we recorded that (PERSON) (or someone in the family) usually pay(s) a {$ AMT COPAY} copayment to (PROVIDER). Is this still the correct copayment amount?

YES ..... 1 {CP03}
NO 2
NOT A COPAYMENT SITUATION ANYMORE ..... 99 {CP03}
REF ..... -7 {CP03}
DK ..... -8 {CP03}

[Code One]

PRESS F1 FOR DEFINITION OF COPAYMENT.

IF CODED '99' (NOT A COPAYMENT SITUATION ANYMORE), DO NOT FLAG THIS PERSON-PROVIDER AS 'COPAYMENT SITUATION' FOR THE CURRENT ROUND.

IF CODED '1' (YES), '-7' (REFUSED), OR '-8' (DON'T KNOW), FLAG THIS PERSON-PROVIDER PAIR AS 'COPAYMENT SITUATION' FOR THE CURRENT ROUND AND SET COPAYMENT AMOUNT FROM THE PREVIOUS ROUND AS THE COPAYMENT AMOUNT FOR THE CURRENT ROUND.

CP02OV
======

What is the correct copayment amount?

[Enter $ Amount] .....
NOT A COPAYMENT SITUATION ANYMORE 99
REF ..... -7
DK ..... -8

SET SMALL DOLLAR AMOUNT ENTERED AT CP02OV AS THE NEW COPAYMENT AMOUNT FOR THIS PERSON-PROVIDER PAIR FOR THE CURRENT ROUND. USE THIS AMOUNT IN CP04.

IF CODED '99' (NOT A COPAYMENT SITUATION ANYMORE), DO NOT FLAG THIS PERSON-PROVIDER AS 'COPAYMENT SITUATION' FOR THE CURRENT ROUND.

IF CODED '-7' (REFUSED), OR '-8' (DON'T KNOW), FLAG THIS PERSON-PROVIDER PAIR AS 'COPAYMENT SITUATION' FOR THE CURRENT ROUND AND SET COPAYMENT AMOUNT FROM PREVIOUS ROUND AS COPAYMENT AMOUNT FOR THE CURRENT ROUND.

RANGE CHECK: DOLLAR AMOUNT MUST BE WHOLE DOLLAR AMOUNT < OR = $50.

CP03
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

Now I'd like to ask you about the charges for {(PERSON)'s stay at (HOSPITAL) that began on (ADMIT DATE)/(PERSON)'s visit to (PROVIDER) on (VISIT DATE)/the last purchase of {NAME OF PRESCRIBED MEDICINE...} for (PERSON)/the services for (FLAT FEE GROUP) for (PERSON)/the {OME ITEM GROUP NAME} used by (PERSON) since (START DATE)/services received at home from (PROVIDER) during (MONTH) for (PERSON)}.

{Let's begin with the charges from the hospital itself, not including any separate physician services or lab tests.}

PRESS ENTER TO CONTINUE.

PRESS F1 FOR DEFINITION OF CHARGE.

IF PERSON-PROVIDER PAIR FLAGGED AS 'COPAYMENT SITUATION' FOR THE CURRENT ROUND, AND THIS EVENT-PROVIDER PAIR DOES NOT REPRESENT A FLAT FEE GROUP, GO TO CP04

IF EVENT TYPE IS OM AND OM GROUP TYPE IS 'ADDITIONAL' (EV02A=2), CONTINUE WITH CP03A

OTHERWISE, GO TO CP05

CP03A
=====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

Did (PERSON) (or anyone in the family) purchase or rent the {OME ITEM GROUP NAME} used by (PERSON)?

CODE '95' IF RESPONDENT VOLUNTEERS OME ITEM GROUP HAD NO CHARGE BECAUSE IT WAS BORROWED OR FREE FROM A CHARITY, ETC.

PURCHASED	1	{CP05}
RENTED	2	{CP05}
NO CHARGE: BORROWED, FREE FROM CHARITY/ORGANIZATION, ETC.	95	{BOX_26}
REF	-7	{CP05}
DK	-8	{CP05}

[Code One]

CP04
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

Is this the type of situation where (PERSON) (or someone in the family) only paid the {$ AMT COPAY} copayment for this visit and (PERSON) (do/does) not know the total charge?

YES 1
NO 2
REF ..... -7
DK ..... -8

[Code One]

PRESS F1 FOR DEFINITION OF COPAYMENT AND TOTAL CHARGE.

IF CODED '1' (YES), COPY ALL PREVIOUS COPAYMENT CHARGE PAYMENT DATA FOR THE PERSON-PROVIDER PAIR TO THIS EVENT-PROVIDER-PAIR. THEN GO TO CP37

IF CODED '2' (NO), '-7' (REFUSED), OR '-8' (DON'T KNOW), IGNORE 'COPAYMENT SITUATION' FLAG FOR THIS PERSON-PROVIDER PAIR FOR THIS EVENT (THAT IS, COLLECT CHARGE/PAYMENT INFORMATION FOR THIS EVENT-PROVIDER PAIR) AND CONTINUE WITH CP05

CP05
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

(Have/Has) (PERSON) (or anyone in the family) received anything in writing, such as a bill, receipt, or statement, for {(PERSON)'s stay at (HOSPITAL) that began on (ADMIT DATE)/ (PERSON)'s visit to (PROVIDER) on (VISIT DATE)/the last purchase of {NAME OF PRESCRIBED MEDICINE...} for (PERSON)/the services for (FLAT FEE GROUP) for (PERSON)/the {OME ITEM GROUP NAME} used by (PERSON) since (START DATE)/services received at home from (PROVIDER) during (MONTH) for (PERSON)}?

PROBE: Include anything in writing received by family members living with (PERSON) as well as those living somewhere else.

YES, AND DOCUMENTATION AVAILABLE ..... 1 {CP08}
YES, BUT DOCUMENTATION NOT AVAILABLE ... 2 {CP08}
NO 3
NO, FREE SAMPLE ..... 4 {CP37}
REF ..... -7
DK ..... -8

[Code One]

PRESS F1 FOR DEFINITION OF ANYTHING IN WRITING.

NOTE: CAPI DISPLAYS CODE '4' (NO, FREE SAMPLE) ONLY IF THE EVENT TYPE OF THE EVENT-PROVIDER PAIR IS PM.

CP06
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

{NAME OF PRESCRIBED MEDICINE...} {OME ITEM GROUP NAME.....}

SHOW CARD CP-1.
Why (have/has) (PERSON) (or anyone in the family) not received anything in writing?
{CODE '95' IF THIS IS A FLAT FEE SITUATION.}

PAID AT TIME OF VISIT	1	{CP08}
MADE A COPAYMENT	2	{CP08}
BILL SENT DIRECTLY TO OTHER SOURCE	3	
BILL HAS NOT ARRIVED	4	{CP08}
NO BILL SENT:		
HMO PLAN	5	{BOX_04}
VA	6	{BOX_04}
MILITARY FACILITY	7	{BOX_04}
PUBLIC ASSISTANCE/MEDICAID/SCHIP	8	{BOX_04}
WORKER'S COMPENSATION	9	{BOX_04}
PRIVATE HEALTH CENTER/CLINIC	10	{BOX_04}
PUBLIC CLINIC/HEALTH CENTER OR PRIVATE CHARITY	11	{BOX_04}
NO CHARGE: TELEPHONE CALL	12	{CP37}
FREE FROM PROVIDER	13	{CP37}
GOVERNMENT-FINANCED RESEARCH AND CLINICAL TRIALS	14	{CP37}
INCLUDED WITH OTHER CHARGES	95	
REF	-7	{CP08}
DK	-8	{CP08}

[Code One]

PRESS F1 FOR DEFINITIONS OF ANSWER CATEGORIES AND FLAT FEE.

NOTE: SHOW CARD FOR CODE '10' WILL READ: 'SCHOOL, EMPLOYER, OR OTHER PRIVATE HEALTH CENTER/CLINIC'. THE SHOW CARD FOR CODE '11' WILL INCLUDE THE FOLLOWING: '(INCLUDE COMMUNITY AND MIGRANT HEALTH CENTER, FEDERALLY QUALIFIED HEALTH CENTER, INDIAN HEALTH SERVICES)'. THE SHOW CARD FOR CODE '13' WILL INCLUDE THE FOLLOWING: '(PROFESSIONAL COURTESY/FREE SAMPLE)'. THESE CODES HAVE BEEN ABBREVIATED TO CONSERVE SPACE ON THE SCREEN.

IF CODED '95' (INCLUDED WITH OTHER CHARGES) AND THE EVENT TYPE OF THE EVENT-PROVIDER PAIR IS PM, DISPLAY THE FOLLOWING MESSAGE: 'THIS CODE IS NOT AVAILABLE FOR A PM EVENT. PRESS ENTER TO CONTINUE.'

IF CODED '95' (INCLUDED WITH OTHER CHARGES) AND THE EVENT-PROVIDER PAIR REPRESENTS A FLAT FEE GROUP, DISPLAY THE FOLLOWING MESSAGE: 'THIS CODE IS NOT AVAILABLE FOR A FLAT FEE GROUP. PRESS ENTER TO CONTINUE.'

IF CODED '95' (INCLUDED WITH OTHER CHARGES) AND THE EVENT-PROVIDER PAIR REPRESENTS A REPEAT VISIT STEM, DISPLAY THE FOLLOWING MESSAGE: 'THIS CODE IS NOT AVAILABLE FOR A REPEAT VISIT GROUP. PRESS ENTER TO CONTINUE.'

IF CODED '95' (INCLUDED WITH OTHER CHARGES) AND THE EVENT TYPE OF THE EVENT-PROVIDER PAIR IS NOT PM AND THE EVENT-PROVIDER PAIR DOES NOT REPRESENT A FLAT FEE GROUP OR A REPEAT VISIT GROUP, ASK THE FLAT FEE (FF) SECTION.

CP07
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

{NAME OF PRESCRIBED MEDICINE...} {OME ITEM GROUP NAME.....}

To whom was the bill sent?

RECORD VERBATIM:

[Enter Text]

CP07OV1
=======

INTERVIEWER: ENTER CODE FOR TYPE OF ORGANIZATION TO WHOM BILL WAS SENT:

HMO	1	
VA	2	
TRICARE/CHAMPVA	3	{CP08}
OTHER MILITARY	4	
PUBLIC ASSISTANCE/MEDICAID/SCHIP	5	
WORKER'S COMPENSATION	6	
PRIVATE INSURANCE COMPANY	7	
OTHER	91	{CP08}
REF	-7	{CP08}
DK	-8	{CP08}

[Code One]

PRESS F1 FOR DEFINITIONS OF ANSWER CATEGORIES.

BOX_04
======

```
 ---------------------------------------------------
|  IF:                                              |
|  -  EVENT TYPE IS OM, HH, OR PM                   |
|  OR                                               |
|  -  EVENT TYPE IS HS                              |
|  OR                                               |
|  -  THIS EVENT-PROVIDER PAIR REPRESENTS A FLAT    |
|     FEE GROUP,                                    |
|  GO TO CP11                                       |
 ---------------------------------------------------

 ---------------------------------------------------
|  OTHERWISE, GO TO CP10                            |
 ---------------------------------------------------
```

CP08
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

Do you know the **total** charge for {(PERSON)'s stay at (HOSPITAL) that began on (ADMIT DATE)/(PERSON)'s visit to (PROVIDER) on (VISIT DATE)/the last purchase of {NAME OF PRESCRIBED MEDICINE...} for (PERSON)/the services for (FLAT FEE GROUP) for (PERSON)/the {OME ITEM GROUP NAME} used by (PERSON) since (START DATE)/services received at home from (PROVIDER) during (MONTH) for (PERSON)}?

{CODE '95' IF THIS IS A FLAT FEE SITUATION.}

YES ..... 1 {CP09}
NO 2
INCLUDED WITH OTHER CHARGES 95
REF ..... -7
DK ..... -8

PRESS F1 FOR DEFINITIONS OF TOTAL CHARGE AND FLAT FEE.

IF CODED '95' (INCLUDED WITH OTHER CHARGES) AND THE EVENT TYPE OF THE EVENT-PROVIDER PAIR IS PM, DISPLAY THE FOLLOWING MESSAGE: 'THIS CODE IS NOT AVAILABLE FOR A PM EVENT. PRESS ENTER TO CONTINUE.'

IF CODED '95' (INCLUDED WITH OTHER CHARGES) AND THE EVENT-PROVIDER PAIR REPRESENTS A FLAT FEE GROUP, DISPLAY THE FOLLOWING MESSAGE: 'THIS CODE IS NOT AVAILABLE FOR A FLAT FEE GROUP. PRESS ENTER TO CONTINUE.'

IF CODED '95' (INCLUDED WITH OTHER CHARGES) AND THE EVENT-PROVIDER PAIR REPRESENTS A REPEAT VISIT STEM, DISPLAY THE FOLLOWING MESSAGE: 'THIS CODE IS NOT AVAILABLE FOR A REPEAT VISIT GROUP. PRESS ENTER TO CONTINUE.'

IF CODED '95' (INCLUDED WITH OTHER CHARGES) AND THE EVENT TYPE IS NOT PM AND THE EVENT-PROVIDER PAIR DOES NOT REPRESENT A FLAT FEE GROUP OR A REPEAT VISIT GROUP, ASK THE FLAT FEE (FF) SECTION.

IF: CODED '2' (NO), '-7' (REFUSED), OR '-8' (DON'T KNOW) AND (EVENT TYPE IS OM, HH, OR PM OR EVENT TYPE IS HS OR THIS EVENT-PROVIDER PAIR REPRESENTS A FLAT FEE GROUP), GO TO CP11

IF: CODED '2' (NO), '-7' (REFUSED), OR '-8' (DON'T KNOW) AND EVENT TYPE IS ER, OP, MV, OR DN GO TO CP10

CP09
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

How much was the total charge for {(PERSON)'s stay at (HOSPITAL) that began on (ADMIT DATE)/(PERSON)'s visit to (PROVIDER) on (VISIT DATE)/the last purchase of {NAME OF PRESCRIBED MEDICINE...} for (PERSON)/the services for (FLAT FEE GROUP) for (PERSON)/the {OME ITEM GROUP NAME} used by (PERSON) since (START DATE)/services received at home from (PROVIDER) during (MONTH) for (PERSON)}?

Please include any amounts that may be paid by health insurance or other sources. {However, please do not include any services billed for separately such as physician charges or other services.}

{If charges for procedures such as x-rays, lab tests, or diagnostic procedures are listed separately on the bill or statement, include those in the total charge.}

IF WORKING FROM DOCUMENTATION, ENTER TOTAL CHARGES. DO NOT DEDUCT DISCOUNTS OR DISALLOWED OR DENIED CHARGES.
{CODE ‘95’ IF THIS IS A FLAT FEE SITUATION.}

AMOUNT 1
INCLUDED WITH OTHER CHARGES 95

[Code One]

PRESS F1 FOR DEFINITION OF WHAT MAKES UP TOTAL CHARGE AND FLAT FEE.

DISPLAY ‘However, please do not include any services billed for separately such as physician charges or other services.’ IF EVENT TYPE IS HS, ER, OR OP. OTHERWISE, USE A NULL DISPLAY. DISPLAY ‘If charges for procedures such as x-rays, lab tests, or diagnostic procedures are listed separately on the bill or statement, include those in the total charge.’ IF CP05 IS CODED ‘1’ (YES, AND DOCUMENTATION AVAILABLE). OTHERWISE, USE A NULL DISPLAY.

IF CODED '95' (INCLUDED WITH OTHER CHARGES) AND THE EVENT TYPE OF THE EVENT-PROVIDER PAIR IS PM, DISPLAY THE FOLLOWING MESSAGE: 'THIS CODE IS NOT AVAILABLE FOR A PM EVENT. PRESS ENTER TO CONTINUE.'

IF CODED '95' (INCLUDED WITH OTHER CHARGES) AND THE EVENT-PROVIDER PAIR REPRESENTS A FLAT FEE GROUP, DISPLAY THE FOLLOWING MESSAGE: 'THIS CODE IS NOT AVAILABLE FOR A FLAT FEE GROUP. PRESS ENTER TO CONTINUE.'

IF CODED '95' (INCLUDED WITH OTHER CHARGES) AND THE EVENT-PROVIDER PAIR REPRESENTS A REPEAT VISIT STEM, DISPLAY THE FOLLOWING MESSAGE: 'THIS CODE IS NOT AVAILABLE FOR A REPEAT VISIT GROUP. PRESS ENTER TO CONTINUE.'

IF CODED '95' (INCLUDED WITH OTHER CHARGES) AND THE EVENT TYPE IS NOT PM AND THE EVENT-PROVIDER PAIR DOES NOT REPRESENT A FLAT FEE GROUP OR A REPEAT VISIT GROUP, ASK THE FLAT FEE (FF) SECTION.

CP09OV
======

ENTER $ AMOUNT:

[Enter $ Amount] .....
REF ..... -7
DK ..... -8

| POSSIBLE SOFT RANGE CHECK: $0 - $100,000 |

| IF THE AMOUNT IS $0, GO TO CP37 |

| IF THE AMOUNT IS NOT $0
AND
(EVENT TYPE IS OM OR PM
OR
THE EVENT-PROVIDER PAIR REPRESENTS A FLAT FEE GROUP
OR
(EVENT TYPE IS HS AND THE EVENT-PROVIDER PAIR IS NOT FLAGGED AS ‘SEPARATELY BILLING’))
GO TO CP11 |

| IF:
EVENT TYPE IS ER, OP, MV, OR DN
AND
TOTAL CHARGE IS A NON-ZERO WHOLE NUMBER < OR = $50.00 OR CP090V IS CODED '-7' (REFUSED) OR '-8' (DON’T KNOW),
GO TO CP10 |

| IF THE AMOUNT IS NOT $0, DK, OR REF AND THE EVENT TYPE IS HH, CONTINUE WITH CPO9A |

| OTHERWISE, GO TO CP11 |

CP09A
=====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

Let me be sure I recorded this correctly. The total charge for the services received at home from (PROVIDER) **during (MONTH)** for (PERSON) was {$ AMOUNT}.

Is that correct?

YES ..... 1 {CP11}
NO 2
REF ..... -7 {CP11}
DK ..... -8 {CP11}

| IF CODED '2' (NO), DISPLAY THE FOLLOWING MESSAGE: |
| 'USE CTRL/B TO CORRECT TOTAL CHARGE FOR THIS MONTH. PRESS ENTER TO CONTINUE.' |

CP10
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

Is this a situation in which (PERSON) (are/is) required to pay a certain set amount each time (PERSON) (visit/visits) (PROVIDER) regardless of what happens during the visit?

PROBE: For example, is this the type of situation in which (PERSON) always (make/makes) the same set dollar amount copayment?

YES 1
NO 2
REF ..... -7
DK ..... -8

PRESS F1 FOR DEFINITION OF SET AMOUNT AND COPAYMENT.

CP11
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

How much of the {{AMT TOT CH}/total charge} did anyone in the family pay for {(PERSON)'s stay at (HOSPITAL) that began on (ADMIT DATE)/(PERSON)'s visit to (PROVIDER) on (VISIT DATE)/the last purchase of {NAME OF PRESCRIBED MEDICINE...} for (PERSON)/ the services for (FLAT FEE GROUP) for (PERSON)/the {OME ITEM GROUP NAME} used by (PERSON) since (START DATE)/services received at home from (PROVIDER) during (MONTH) for (PERSON)}? Please include all amounts paid 'out-of-pocket,' that is, amounts paid before any reimbursements.

IF AMOUNT PAID IS NOTHING, DK, OR REF, ENTER 1 FOR DOLLARS, THEN RESPONSE.

IS ANSWER IN DOLLARS OR PERCENT?

DOLLARS 1
PERCENT ..... 2 {CP11OV2}

[Code One]

PRESS F1 FOR INFORMATION ON AMOUNTS TO INCLUDE.

CP11OV1
=======

ENTER DOLLARS:

[Enter $ Amount] .....
REF ..... -7
DK ..... -8

| SOFT RANGE CHECK: $0 - $10,000 |

| WRITE 'PERSON/FAMILY' TO THE RU-SOURCES-OF-PAYMENT-ROSTER. |

| WRITE 'PERSON/FAMILY' TO THE EVENT'S-SOURCES-OF-PAYMENT-ROSTER. |

| GO TO BOX_05 |

CP11OV2
=======

ENTER PERCENT:

[Enter Percent %] .....

| SOFT RANGE CHECK: 1% - 100% |

| MULTIPLY THE PERCENTAGE ENTERED BY THE TOTAL CHARGE ENTERED AT CP09 TO CALCULATE THE AMOUNT PAID BY THE FAMILY AT CP11. |

| IF CP09 IS CODED '-7' (REFUSED), OR '-8' (DON'T KNOW), DOLLAR AMOUNT PAID BY FAMILY CANNOT BE CALCULATED. RECORD DOLLAR AMOUNT PAID BY PERSON/FAMILY AS 'DK' OR 'REF' AS APPROPRIATE. |

| WRITE 'PERSON/FAMILY' TO THE RU-SOURCES-OF-PAYMENT-ROSTER. |

| WRITE 'PERSON/FAMILY' TO THE EVENT'S-SOURCES-OF-PAYMENT-ROSTER. |

BOX_05
======

IF: CP11OV1 OR CP11OV2 IS CODED '-7' (REFUSED) OR '-8' (DON'T KNOW) AND CP08 IS CODED '2' (NO), '-7' (REFUSED), OR '-8' (DON'T KNOW) AND CP10 IS CODED '2' (NO), '-7' (REFUSED), OR '-8' (DON'T KNOW), DISPLAY THE FOLLOWING MESSAGE: 'NO CHARGE-PAYMENT RESOLUTION WILL BE NEEDED FOR THIS CASE. PRESS ENTER TO CONTINUE.' THEN GO TO CP37

OTHERWISE, CONTINUE WITH LOOP_01

LOOP_01
=======

FOR EACH OF THE FOLLOWING: SOURCE OF DIRECT PAYMENT 1 SOURCE OF DIRECT PAYMENT 2 SOURCE OF DIRECT PAYMENT 3 SOURCE OF DIRECT PAYMENT 4 ASK BOX_LP01-END_LP01

LOOP DEFINITION: LOOP_01 COLLECTS INFORMATION ON SOURCES OF DIRECT PAYMENTS AND ASSOCIATED PAYMENT AMOUNTS, OTHER THAN PERSON/FAMILY. THE RESPONSE TO CP13OV DETERMINES WHETHER THE LOOP CYCLES AGAIN. SUBSEQUENT CYCLES, IF ANY, COLLECT ADDITIONAL SOURCES OF DIRECT PAYMENT AND ASSOCIATED AMOUNTS. IF CP13OV IS CODED ‘1’ (YES), THE LOOP CYCLES AGAIN. IF CP13OV IS NOT ASKED OR IS CODED ‘2’ (NO), THE LOOP ENDS.

BOX_LP01
========

IF FIRST CYCLE OF LOOP_01, CONTINUE WITH CP12

OTHERWISE (I.E., IF ANY CYCLE SUBSEQUENT TO THE FIRST CYCLE OF LOOP_01), GO TO CP12A

CP12
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

Has any {other} source already paid {(PROVIDER)} for any of the charges for {(PERSON)'s stay at (HOSPITAL) that began on (ADMIT DATE)/(PERSON)'s visit to (PROVIDER) on (VISIT DATE)/the last purchase of {NAME OF PRESCRIBED MEDICINE...} for (PERSON)/ the services for (FLAT FEE GROUP) for (PERSON)/the {OME ITEM GROUP NAME.....} used by (PERSON) since (START DATE)/for services received at home from (PROVIDER) during (MONTH) for (PERSON)}?

YES 1
NO ..... 2 {END_LP01}
REF ..... -7 {END_LP01}
DK ..... -8 {END_LP01}

PRESS F1 FOR A DEFINITION OF SOURCE AND ‘ALREADY PAID’.

DISPLAY ‘OTHER’ IN THE QUESTION TEXT IF AN AMOUNT WAS PAID BY PERSON/FAMILY; THAT IS, AN AMOUNT > $0 OR 0% WAS ENTERED AT CP11OV1 OR CP11OV2

DISPLAY ‘(PROVIDER)’ IN THE QUESTION TEXT IF EVENT TYPE IS NOT PM OR OM.

CP12A
=====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

{NAME OF PRESCRIBED MEDICINE...} {OME ITEM GROUP NAME.....}

Who else paid? PROBE: Anyone else?

TO TURN CHECK MARK ON/OFF, USE ARROW KEYS, PRESS ENTER.
TO ADD, PRESS CTRL/A. TO DELETE, PRESS CTRL/D.
TO LEAVE, PRESS ESC.

[1. Name of Source of Direct Payment-35]
[2. Name of Source of Direct Payment-35]
[3. Name of Source of Direct Payment-35]

ROSTER DEFINITION: THIS ITEM DISPLAYS ALL SOURCES ON THE RU-SOURCES-OF-PAYMENT-ROSTER.

WRITE SOURCES SELECTED TO THE EVENT'S-SOURCES-OF-PAYMENTS-ROSTER.

SOURCE ROSTER BEHAVIOR SPECIFICATIONS:
1. INTERVIEWER MAY SELECT A SOURCE(S) ALREADY LISTED ON THE ROSTER.
2. INTERVIEWER SHOULD BE ABLE TO ADD ANY NUMBER OF SOURCES AT THE ROSTER QUESTIONS (I.E., NO LIMIT TO THE NUMBER OF SOURCES).
3. INTERVIEWER SHOULD BE ABLE TO DELETE A SOURCE THAT WAS RECORDED ON THE SCREEN WHERE DELETE IS USED. THAT IS, AS LONG AS THE INTERVIEWER HAS NOT LEFT THE SCREEN, SHE SHOULD BE ABLE TO DELETE A SOURCE ENTERED IN ERROR. IF DELETE IS ATTEMPTED AT A TIME WHEN IT IS NOT ALLOWED (I.E., AFTER THE LINK IS ESTABLISHED), DISPLAY THE FOLLOWING ERROR MESSAGE: 'DELETE ALLOWED ONLY WHEN SOURCE IS FIRST ENTERED.'

CP13
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

{NAME OF PRESCRIBED MEDICINE...} {OME ITEM GROUP NAME.....}

How much did (SOURCE) pay?

ENTER AMOUNT PAID TO COLUMN 2 OR COLUMN 3.
TO MOVE CURSOR, USE ARROW KEYS. TO LEAVE, PRESS ESC.

TOTAL CHARGE: {$XXXXXXXXX}

ROSTER. SOURCE OF PAYMENT	CP13_02. DOLLAR AMOUNT PAID	CP13_03. PERCENT AMOUNT PAID
PERSON/Family	[Display $ Amount]	[Display % Amount]
[Display Source of Payment]	[Enter $ Amount]	[Enter % Amount]
[Display Source of Payment]	[Enter $ Amount]	[Enter % Amount]

ROSTER DEFINITION: THIS ITEM DISPLAYS ALL SOURCES ON THE EVENT'S-SOURCES-OF-PAYMENT-ROSTER, THAT IS, ALL SOURCES SELECTED AT CP12A FOR THIS EVENT-PROVIDER PAIR AND THE 'PERSON/FAMILY' RECORD.

TOTAL CHARGE: DISPLAY AMOUNT ENTERED AT CP09.

FLAG ALL SOURCES AND ASSOCIATED AMOUNTS AS 'DIRECT PAYMENT'.

DISPLAY 'PERSON/FAMILY' AS THE FIRST SOURCE OF PAYMENT.

DISPLAY THE RESPONSE TO CP11 IN THE 'AMOUNT PAID' COLUMN FOR PERSON/FAMILY. THAT IS, IF THE RESPONSE TO CP11OV1 IS AN AMOUNT, DISPLAY THE DOLLAR AMOUNT IN CP13_02, ‘DOLLAR AMOUNT PAID’. IF THE RESPONSE TO CP11OV2 IS A PERCENTAGE, DISPLAY THE PERCENTAGE AMOUNT IN CP13_03, ‘PERCENT AMOUNT PAID’. IF CP11OV1 OR CP11OV2 IS CODED ‘-8’ (DON’T KNOW), DISPLAY ‘DK’ FOR THE AMOUNT IN BOTH CP13_02 AND CP13_03. IF CP11OV1 OR CP11OV2 IS CODED ‘-7’ (REFUSED), DISPLAY ‘REF’ FOR THE AMOUNT IN BOTH CP13_02 AND CP13_03.

NOTE: **FEATURES OF THE SOURCE OF PAYMENT MATRIX.**

1. INTERVIEWER USES RIGHT AND LEFT ARROW KEYS TO MOVE TO EITHER THE PERCENT OR DOLLAR AMOUNT COLUMN ASSOCIATED WITH THAT SOURCE. INTERVIEWER USES THE UP AND DOWN ARROW KEYS TO MOVE BETWEEN AMOUNT PAID COLUMNS FOR DIFFERENT SOURCES.
2. SOURCE COLUMN IS PROTECTED. CURSOR WILL NOT ENTER THIS COLUMN, SO NO CHANGES ARE ALLOWED TO SOURCES AT THIS SCREEN.
3. INTERVIEWER ENTERS EITHER A DOLLAR OR A PERCENTAGE AMOUNT FOR EACH SOURCE DISPLAYED. AMOUNTS CAN BE CHANGED AS MANY TIMES AS NECESSARY BEFORE THE INTERVIEWER LEAVES THE SCREEN.
4. THE PERSON/FAMILY AMOUNT PAID COLUMNS MAY BE CHANGED OR CORRECTED.
5. WHEN CURSOR LEAVES THE CELL AND A DOLLAR OR PERCENTAGE AMOUNT HAS BEEN ENTERED AND THERE IS A TOTAL CHARGE, THE RECIPROCAL AMOUNT WILL BE DISPLAYED. FOR EXAMPLE, IF THE INTERVIEWER ENTERS A PERCENTAGE, THE DOLLAR AMOUNT WILL BE CALCULATED USING THE TOTAL CHARGE. THIS DOLLAR AMOUNT WOULD THEN BE DISPLAYED IN THE DOLLAR AMOUNT PAID COLUMN (NEXT TO THE PERCENT AMOUNT PAID COLUMN).
6. IF A SOURCE IS ENTERED IN ERROR, THE INTERVIEWER WILL ZERO OUT THE AMOUNT PAID.
7. INTERVIEWERS WILL BE INSTRUCTED TO ONLY ENTER DIRECT PAYMENTS MADE TO THE PROVIDER AT THIS SCREEN.
8. THE CURSOR SHOULD FIRST APPEAR IN THE DOLLAR AMOUNT PAID COLUMN FOR THE FIRST SOURCE ADDED/SELECTED AT THE PREVIOUS SCREEN (NOT IN THE PERSON/FAMILY COLUMN).

CP130V
======

DID ANY OTHER SOURCES MAKE ANY PAYMENTS DIRECTLY TO THE PROVIDER?

YES 1
NO 2

PRESS F1 FOR A DEFINITION OF PAYMENTS MADE DIRECTLY TO PROVIDER.

END_LP01
========

IF CP13OV IS CODED '1' (YES), CYCLE TO COLLECT NEXT SOURCE OF PAYMENT.

IF CP13OV IS NOT ASKED OR IS CODED '2' (NO), END LOOP_01 AND CONTINUE WITH BOX_06

BOX_06
======

IF 'AMOUNT PAID' BY PERSON/FAMILY > $0, CONTINUE WITH LOOP_02

OTHERWISE, GO TO BOX_07

LOOP_02
=======

FOR EACH OF THE FOLLOWING: SOURCE OF REIMBURSEMENT 1 SOURCE OF REIMBURSEMENT 2 SOURCE OF REIMBURSEMENT 3 SOURCE OF REIMBURSEMENT 4 ASK BOX_LP02-END_LP02

LOOP DEFINITION: LOOP_02 COLLECTS INFORMATION ON SOURCES OF REIMBURSEMENT TO PERSON/FAMILY AND ASSOCIATED REIMBURSEMENT AMOUNTS. THE RESPONSE TO CP15OV DETERMINES WHETHER THE LOOP CYCLES AGAIN. SUBSEQUENT CYCLES, IF ANY, COLLECT ADDITIONAL SOURCES OF REIMBURSEMENT AND ASSOCIATED AMOUNTS. IF CP15OV IS CODED '1' (YES), THE LOOP CYCLES AGAIN. IF CP15OV IS NOT ASKED OR IS CODED '2' (NO), THE LOOP ENDS.

BOX_LP02
========

IF FIRST CYCLE OF LOOP_02, CONTINUE WITH CP14

OTHERWISE (I.E., IF ANY CYCLE SUBSEQUENT TO THE FIRST CYCLE OF LOOP_02), GO TO CP14A

CP14
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

{NAME OF PRESCRIBED MEDICINE...} {OME ITEM GROUP NAME.....}

Has any source reimbursed or paid back anything to (PERSON) (or anyone in the family) for the amount paid 'out-of-pocket'? That is, has any source reimbursed any of the {$/% FAMILY PAID} paid?

YES 1
NO ..... 2 {END_LP02}
REF ..... -7 {END_LP02}
DK ..... -8 {END_LP02}

PRESS F1 FOR DEFINITION OF SOURCE AND REIMBURSEMENT.

CP14A
=====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

{NAME OF PRESCRIBED MEDICINE...} {OME ITEM GROUP NAME.....}

Who reimbursed or paid anyone in the family back?

PROBE: Anyone else?

TO TURN CHECK MARK ON/OFF, USE ARROW KEYS, PRESS ENTER.
TO ADD, PRESS CTRL/A. TO DELETE, PRESS CTRL/D.
TO LEAVE, PRESS ESC.

[1. Name of Source of Reimbursement-35]
[2. Name of Source of Reimbursement-35]
[3. Name of Source of Reimbursement-35]

ROSTER DEFINITION: THIS ITEM DISPLAYS ALL SOURCES ON THE RU-SOURCES-OF-PAYMENT-ROSTER EXCLUDING THE 'PERSON/FAMILY' RECORD.

WRITE SOURCES SELECTED TO THE EVENT'S-SOURCES-OF-PAYMENTS-ROSTER.

NOTE: SOURCES OF PAYMENTS AND SOURCES OF REIMBURSEMENTS ARE SELECTED FROM THE SAME RU LEVEL ROSTER OF SOURCES AND ROSTER BEHAVIOR IS THE SAME.

CP15
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

{NAME OF PRESCRIBED MEDICINE...} {OME ITEM GROUP NAME.....}

How much did (SOURCE) reimburse or pay anyone in the family back?

ENTER THE AMOUNT REIMBURSED IN COLUMN 2 OR COLUMN 3.
TO MOVE CURSOR, USE ARROW KEYS. TO LEAVE, PRESS ESC.

PERSON/FAMILY PAYMENT: {$XXXXXXXXX} TOTAL CHARGE: {$XXXXXXXXX}

ROSTER. SOURCE OF REIMBURSEMENT	CP15_02. DOLLAR AMOUNT REIMBURSED	CP15_03. PERCENT AMOUNT REIMBURSED
[Display Source of Reimbursement]	[Enter $ Amount]	[Enter % Amount]
[Display Source of Reimbursement]	[Enter $ Amount]	[Enter % Amount]

ROSTER DEFINITION: THIS ITEM DISPLAYS ALL SOURCES ON THE EVENT'S-SOURCES-OF-PAYMENT-ROSTER, THAT IS, ALL SOURCES SELECTED AT CP14A FOR THIS EVENT-PROVIDER PAIR.

TOTAL CHARGE: DISPLAY AMOUNT ENTERED AT CP09.

FLAG ALL SOURCES AND ASSOCIATED AMOUNTS AS 'REIMBURSEMENT'.

NOTE: **FEATURES OF THE REIMBURSEMENT MATRIX.**

1. INTERVIEWER USES RIGHT AND LEFT ARROW KEYS TO MOVE TO EITHER THE PERCENT OR DOLLAR AMOUNT COLUMN ASSOCIATED WITH THAT SOURCE. INTERVIEWER USES THE UP AND DOWN ARROW KEYS TO MOVE BETWEEN AMOUNT PAID COLUMNS FOR DIFFERENT SOURCES.
2. SOURCE COLUMN IS PROTECTED. CURSOR WILL NOT ENTER THIS COLUMN, SO NO CHANGES ARE ALLOWED TO SOURCES AT THIS SCREEN.
3. INTERVIEWER ENTERS EITHER A DOLLAR OR A PERCENTAGE AMOUNT FOR EACH SOURCE DISPLAYED. AMOUNTS CAN BE CHANGED AS MANY TIMES AS NECESSARY BEFORE THE INTERVIEWER LEAVES THE SCREEN.
4. WHEN CURSOR LEAVES THE CELL AND A DOLLAR OR PERCENTAGE AMOUNT HAS BEEN ENTERED AND THERE IS A TOTAL CHARGE, THE RECIPROCAL AMOUNT WILL BE DISPLAYED. FOR EXAMPLE, IF THE INTERVIEWER ENTERS A PERCENTAGE, THE DOLLAR AMOUNT WILL BE CALCULATED USING THE TOTAL CHARGE. THIS DOLLAR AMOUNT WOULD THEN BE DISPLAYED IN THE DOLLAR AMOUNT REIMBURSED COLUMN (NEXT TO PERCENT AMOUNT REIMBURSED).
5. IF A SOURCE IS ENTERED IN ERROR, THE INTERVIEWER WILL ZERO OUT THE AMOUNT REIMBURSED.
6. INTERVIEWERS WILL BE INSTRUCTED TO ONLY ENTER REIMBURSEMENTS MADE TO THE FAMILY AT THIS SCREEN.
7. IF THE TOTAL AMOUNT REIMBURSED BY ALL SOURCES EXCEEDS THE AMOUNT PAID BY THE PERSON/FAMILY, CAPI DISPLAYS THE MESSAGE: ‘REIMBURSED AMOUNT GREATER THAN FAMILY PAYMENT. VERIFY REIMBURSED AMOUNT AND RE-ENTER. IF NEED TO CORRECT FAMILY PAYMENT, JUMPBACK TO CP13.’ IF INTERVIEWER RE-ENTERS THE SAME AMOUNTS, CAPI WILL ACCEPT. THAT IS, WE WILL INFORM THE INTERVIEWER OF THE DISCREPANCY, BUT NOT FORCE HER TO RECONCILE IT.
8. THE SAME SOURCE CAN BE FLAGGED AS BOTH A REIMBURSEMENT AND A DIRECT PAYMENT. ONLY THE AMOUNT ASSOCIATED WITH THE DIRECT PAYMENT WILL PLAY INTO THE RESOLUTION PROCESS.
9. POST DATA COLLECTION EDITING WILL BE NECESSARY TO DETERMINE THE NET PAYMENTS OF SOURCES.

CP15OV
======

ARE THERE ANY OTHER SOURCES OF REIMBURSEMENT?

YES 1
NO 2

PRESS F1 FOR DEFINITION OF REIMBURSEMENT.

END_LP02
========

| IF CP15OV CODED '1' (YES), CYCLE TO COLLECT NEXT SOURCE OF REIMBURSEMENT |

| IF CP15OV IS NOT ASKED OR IS CODED '2' (NO), END LOOP_02 AND CONTINUE WITH BOX_07 |

BOX_07
======

| GO TO BOX_11 |

BOX_08
======

OMITTED.

CP16
====

OMITTED.

CP17
====

OMITTED.

CP17OV1
=======

OMITTED.

CP17OV2
=======

OMITTED.

BOX_11
======

IF CP14 IS CODED ‘2’ (NO), ‘-7’ (REFUSED), OR ‘-8’ (DON’T KNOW) AND CP10 IS CODED ‘1’ (YES), GO TO BOX_09
OTHERWISE, CONTINUE WITH BOX_10
NOTE: THIS BOX SKIPS PEOPLE OVER CP18 (EXPECT ANY REIMBURSEMENT) FOR INDIVIDUALS WHO HAVE ALREADY TOLD US THAT THE PAYMENT WAS A COPAYMENT (CP10 IS CODED ‘1’) AND THEY HAVE NOT BEEN REIMBURSED FOR ANY AMOUNT PAID (CP14 IS CODED ‘2’, ‘-7’, OR ‘-8’).

BOX_10
======

IF AMOUNT PAID BY PERSON/FAMILY IS > $0, CONTINUE WITH CP18
OTHERWISE, GO TO BOX_09

CP18
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

Do you expect any {other} source to reimburse anyone in the family for what has been paid?

YES 1
NO ..... 2 {BOX_09}
REF ..... -7 {BOX_09}
DK ..... -8 {BOX_09}

PRESS F1 FOR DEFINITION OF REIMBURSEMENT.

| DISPLAY 'OTHER' IN THE QUESTION TEXT IF CP14 IS CODED '1' (YES). |

CP19
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

How much does anyone in the family expect to be reimbursed?

PROBE: Include amounts to be reimbursed from all sources.

IS ANSWER IN DOLLARS OR PERCENT?

DOLLARS 1
PERCENT ..... 2 {CP19OV2}

[Code One]

CP19OV1
=======

ENTER DOLLARS:

[Enter $ Amount] ..... {CP20}
REF ..... -7 {CP20}
DK ..... -8 {CP20}

| SOFT RANGE CHECK: $0 - $10,000 |

CP19OV2
=======

ENTER PERCENT:

[Enter % Amount] .....
REF ..... -7
DK ..... -8

| SOFT RANGE CHECK: 1% - 100% |

CP20
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

From whom do you expect these reimbursements to come?

IF MORE THAN ONE SOURCE OF REIMBURSEMENT, PROBE FOR THE MAIN SOURCE (I.E., THE SOURCE REIMBURSING THE MOST).

TO TURN CHECK MARK ON/OFF, USE ARROW KEYS, PRESS ENTER.
TO ADD, PRESS CTRL/A. TO DELETE, PRESS CTRL/D.
TO LEAVE, PRESS ESC.

[1. Name of Source of Direct Payment-35]
[2. Name of Source of Direct Payment-35]
[3. Name of Source of Direct Payment-35]

[Code One]

ROSTER DEFINITION: THIS ITEM DISPLAYS ALL SOURCES ON THE RU-SOURCES-OF-PAYMENT-ROSTER EXCLUDING THE 'PERSON/FAMILY' RECORD.

WRITE SOURCES SELECTED TO THE EVENT'S-SOURCES-OF-PAYMENTS-ROSTER.

REFER TO CP12 FOR SOURCE OF PAYMENT ROSTER BEHAVIOR SPECIFICATIONS.

BOX_09
======

DETERMINE IF THERE IS AN OVERPAYMENT OR UNDERPAYMENT: SUBTRACT THE TOTAL PAYMENT FROM THE TOTAL CHARGE AT CP09. IF THE ABSOLUTE VALUE OF THE REMAINDER IS > 3% OR $5 (WHICHEVER IS HIGHER) OF THE TOTAL CHARGE, CONTINUE WITH BOX_12

OTHERWISE, DISPLAY THE FOLLOWING MESSAGE: 'NO CHARGE-PAYMENT RESOLUTION NEEDED FOR THIS CASE. PRESS ENTER TO CONTINUE.' THEN GO TO CP37

BOX_12
======

IF CP09 (TOTAL CHARGE) OR 'AMOUNT PAID' BY ANY SOURCE OF DIRECT PAYMENT (INCLUDING PERSON/FAMILY, BUT EXCLUDING REIMBURSEMENTS) IS CODED '-7' (REFUSED) OR '-8' (DON'T KNOW), DISPLAY THE FOLLOWING MESSAGE: 'NO CHARGE-PAYMENT RESOLUTION NEEDED FOR THIS CASE. PRESS ENTER TO CONTINUE.' THEN GO TO CP37

OTHERWISE, CONTINUE WITH BOX_13

BOX_13
======

IF THE UNDERPAYMENT IS > 3% OR $5 (WHICHEVER IS HIGHER) OF THE TOTAL CHARGE, CONTINUE WITH CP21

IF THE OVERPAYMENT IS > 3% OR $5 (WHICHEVER IS HIGHER) OF THE TOTAL CHARGE, GO TO LOOP_04

CP21
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

Does anyone in the family **or** any other source expect to make additional payments for {(PERSON)'s stay at (HOSPITAL) that began on (ADMIT DATE)/(PERSON)'s visit to (PROVIDER) on (VISIT DATE)/the last purchase of {NAME OF PRESCRIBED MEDICINE...} for (PERSON)/the services for (FLAT FEE GROUP) for (PERSON)/the {OME ITEM GROUP NAME} used by (PERSON) since (START DATE)/services received at home from (PROVIDER) during (MONTH) for (PERSON)}?

YES 1
NO ..... 2 {LOOP_03}
REF ..... -7 {LOOP_03}
DK ..... -8 {LOOP_03}

CP22
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

How much more does anyone in the family or any other source expect to pay?

IS ANSWER IN DOLLARS OR PERCENT?

DOLLARS 1
PERCENT ..... 2 {CP22OV2}

[Code One]

CP22OV1
=======

ENTER DOLLARS:

[Enter $ Amount] ..... {BOX_14}
REF ..... -7 {BOX_14}
DK ..... -8 {BOX_14}

| SOFT RANGE CHECK: $0 - $10,000 |

CP22OV2
=======

ENTER PERCENT:

[Enter % Amount] .....
REF ..... -7
DK ..... -8

| SOFT RANGE CHECK: 1% - 100% |

BOX_14
======

```
 ------------------------------------------------------
|  IF AN AMOUNT IS ENTERED AT CP22OV1 OR AT CP22OV2    |
|  OR IF CP22OV1 OR CP22OV2 ARE CODED '-7'             |
|  (REFUSED) OR '-8' (DON'T KNOW), DISPLAY THE         |
|  FOLLOWING MESSAGE:  'NO CHARGE-PAYMENT              |
|  RESOLUTION NEEDED FOR THIS CASE.  PRESS ENTER TO    |
|  CONTINUE.'  THEN GO TO CP37                         |
 ------------------------------------------------------
```

LOOP_03
=======

```
 ------------------------------------------------------
|  FOR EACH OF THE FOLLOWING:                          |
|                                                      |
|  SOURCE OF DIRECT PAYMENT 1                          |
|  SOURCE OF DIRECT PAYMENT 2                          |
|  SOURCE OF DIRECT PAYMENT 3                          |
|  SOURCE OF DIRECT PAYMENT 4                          |
|                                                      |
|  ASK BOX_LP03-END_LP03                               |
 ------------------------------------------------------

 ------------------------------------------------------
|  LOOP DEFINITION:  LOOP_03 REVIEWS PAYMENT           |
|  INFORMATION WHERE AN UNDERPAYMENT HAS BEEN          |
|  REPORTED AND EITHER VERIFIES THE UNDERPAYMENT OR    |
|  COLLECTS CORRECTIONS AND ADDITIONAL PAYMENT         |
|  INFORMATION TO RESOLVE THE UNDERPAYMENT.  THE       |
|  FIRST CYCLE OF THIS LOOP COLLECTS CORRECTIONS OF    |
|  ERRONEOUS INFORMATION ON DIRECT PAYMENTS AND THE    |
|  THE ASSOCIATED  AMOUNTS PAID.  SUBSEQUENT LOOP      |
|  CYCLES, IF ANY, COLLECT ADDITIONAL SOURCES OF       |
|  DIRECT PAYMENT AND ASSOCIATED AMOUNTS.  THE         |
|  RESPONSE TO CP24OV DETERMINES WHETHER THE LOOP      |
|  CYCLES AGAIN.  IF CP24OV IS CODED '1' (YES), THE    |
|  LOOP CYCLES AGAIN.  IF CP24OV IS CODED '2' (NO),    |
|  THE LOOP ENDS.                                      |
 ------------------------------------------------------
```

BOX_LP03
========

IF FIRST CYCLE OF LOOP_03, GO TO CP24

OTHERWISE (I.E., IF ANY CYCLE SUBSEQUENT TO THE FIRST CYCLE OF LOOP_03), CONTINUE WITH CP23

CP23
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

{NAME OF PRESCRIBED MEDICINE...} {OME ITEM GROUP NAME.....}

Who else paid? PROBE: Anyone else?

TO TURN CHECK MARK ON/OFF, USE ARROW KEYS, PRESS ENTER.
TO ADD, PRESS CTRL/A. TO DELETE, PRESS CTRL/D.
TO LEAVE, PRESS ESC.

[1. Name of Source of Direct Payment-35]
[2. Name of Source of Direct Payment-35]
[3. Name of Source of Direct Payment-35]

ROSTER DEFINITION: THIS ITEM DISPLAYS ALL SOURCES ON THE RU-SOURCES-OF-PAYMENT-ROSTER.

WRITE SOURCES SELECTED TO THE EVENT’S-SOURCES-OF-PAYMENTS-ROSTER.

REFER TO CP12A FOR SOURCE OF PAYMENT ROSTER BEHAVIOR SPECIFICATIONS.

CP24
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

At the moment, it appears that {AMOUNT REMAINING} of the total charge for {(PERSON)'s stay at (HOSPITAL) that began on (ADMIT DATE)/(PERSON)'s visit to (PROVIDER) on (VISIT DATE)/the last purchase of {NAME OF PRESCRIBED MEDICINE...} for (PERSON)/the services for (FLAT FEE GROUP) for (PERSON)/the {OME ITEM GROUP NAME.....} used by (PERSON) since (START DATE)/services received at home from (PROVIDER) during (MONTH) for (PERSON)} is still unpaid. Let me be sure I have entered everything correctly.

REVIEW CHARGES AND PAYMENTS WITH RESPONDENT. WORK WITH RESPONDENT TO CORRECT ERRONEOUS INFORMATION, IF ANY.

IF TOTAL CHARGE NEEDS CORRECTION, JUMPBACK TO CP09.
TO MOVE CURSOR, USE ARROW KEYS. TO LEAVE, PRESS ESC.

UNDERPAYMENT: {$XXXXXXXXX} TOTAL CHARGE: {$XXXXXXXXX}

ROSTER. SOURCE OF PAYMENT	CP24_02. DOLLAR AMOUNT PAID	CP24_03. PERCENT AMOUNT PAID
PERSON/Family	[Display $ Amount]	[Display % Amount]
[Display Source of Payment]	[Display $ Amount]	[Display % Amount]
[Display Source of Payment]	[Enter $ Amount]	[Enter % Amount]

ROSTER DEFINITION: THIS ITEM DISPLAYS ALL SOURCES ON THE EVENT'S-SOURCES-OF-PAYMENT-ROSTER THAT ARE FLAGGED AS 'DIRECT PAYMENT' AND THE ASSOCIATED DIRECT PAYMENT AMOUNTS.

TOTAL CHARGE: DISPLAY AMOUNT ENTERED AT CP09.

DISPLAY 'PERSON/FAMILY' AS THE FIRST SOURCE OF PAYMENT. IF THE AMOUNT PAID BY PERSON/FAMILY WAS ADJUSTED AT CP13, DISPLAY ADJUSTED AMOUNT. IF AMOUNT PAID BY PERSON/FAMILY WAS NOT ADJUSTED, DISPLAY THE RESPONSE TO CP11 IN THE 'AMOUNT PAID' COLUMN FOR PERSON/FAMILY. THAT IS, IF THE RESPONSE TO CP11OV1 IS AN AMOUNT, DISPLAY THE DOLLAR AMOUNT IN CP24_02, 'DOLLAR AMOUNT PAID'. IF THE RESPONSE TO CP11OV2 IS A PERCENTAGE, DISPLAY THE PERCENTAGE AMOUNT IN CP24_03, 'PERCENT AMOUNT PAID'. IF CP11OV1 OR CP11OV2 IS CODED '-8' (DON'T KNOW), DISPLAY 'DK' FOR THE AMOUNT IN BOTH CP24_02 AND CP24_03. IF CP11OV1 OR CP11OV2 IS CODED '-7' (REFUSED), DISPLAY 'REF' FOR THE AMOUNT IN BOTH CP24_02 AND CP24_03.

FLAG ALL SOURCES AND ASSOCIATED AMOUNTS AS 'DIRECT PAYMENTS'.

NOTE: **FEATURES OF THE SOURCE OF PAYMENT MATRIX.** 1. THIS MATRIX WILL WORK JUST LIKE THE SOURCE OF PAYMENT MATRIX AT CP13. HOWEVER IN THIS FIRST STAGE RESOLUTION PROCESS, ONLY CORRECTIONS TO DIRECT PAYMENTS CAN BE MADE. AS WELL, ONLY NEW SOURCES OF DIRECT PAYMENTS MAY BE ADDED. AT NO TIME IN THIS FIRST STAGE RESOLUTION PROCESS CAN ANY CORRECTIONS OR UPDATES BE MADE TO SOURCE NAMES OR AMOUNTS OF REIMBURSEMENTS.

CP24OV
======

DID ANY OTHER SOURCES MAKE ANY PAYMENTS DIRECTLY TO THE PROVIDER?

YES 1
NO 2

PRESS F1 FOR A DEFINITION OF PAYMENTS MADE DIRECTLY TO PROVIDER.

END_LP03
========

IF CP24OV IS CODED '1' (YES), CYCLE TO COLLECT ADDITIONAL SOURCES OF PAYMENT.

IF CP24OV IS CODED '2' (NO), END LOOP_03 AND GO TO BOX_15

LOOP_04
=======

FOR EACH OF THE FOLLOWING: SOURCE OF DIRECT PAYMENT 1 SOURCE OF DIRECT PAYMENT 2 SOURCE OF DIRECT PAYMENT 3 SOURCE OF DIRECT PAYMENT 4 ASK BOX_LP04-END_LP04

LOOP DEFINITION: LOOP_04 REVIEWS PAYMENT INFORMATION WHERE AN OVERPAYMENT HAS BEEN REPORTED AND EITHER VERIFIES THE OVERPAYMENT OR COLLECTS CORRECTIONS AND ADDITIONAL PAYMENT INFORMATION TO RESOLVE THE OVERPAYMENT. THE FIRST CYCLE OF THIS LOOP COLLECTS CORRECTIONS OF ERRONEOUS INFORMATION ON DIRECT PAYMENTS AND ASSOCIATED AMOUNTS PAID. SUBSEQUENT LOOP CYCLES, IF ANY, COLLECT ADDITIONAL SOURCES OF DIRECT PAYMENT AND ASSOCIATED AMOUNTS. THE RESPONSE TO CP26OV DETERMINES WHETHER THE LOOP CYCLES AGAIN. IF CP26OV IS CODED '1' (YES), THE LOOP CYCLES AGAIN. IF CP26OV IS CODED '2' (NO), THE LOOP ENDS.

BOX_LP04
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IF FIRST CYCLE OF LOOP_04, GO TO CP26

OTHERWISE (I.E., IF ANY CYCLE SUBSEQUENT TO THE FIRST CYCLE OF LOOP_04), CONTINUE WITH CP25

CP25
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{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

{NAME OF PRESCRIBED MEDICINE...} {OME ITEM GROUP NAME.....}

Who else paid? PROBE: Anyone else?

TO TURN CHECK MARK ON/OFF, USE ARROW KEYS, PRESS ENTER.
TO ADD, PRESS CTRL/A. TO DELETE, PRESS CTRL/D.
TO LEAVE, PRESS ESC.

[1. Name of Source of Direct Payment-35]
[2. Name of Source of Direct Payment-35]
[3. Name of Source of Direct Payment-35]

ROSTER DEFINITION: THIS ITEM DISPLAYS ALL SOURCES ON THE RU-SOURCES-OF-PAYMENT-ROSTER.

WRITE SOURCES SELECTED TO THE EVENT’S-SOURCES-OF-PAYMENTS-ROSTER.

REFER TO CP12 FOR SOURCE OF PAYMENT ROSTER BEHAVIOR SPECIFICATIONS.

CP26
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{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

The payments you reported for {(PERSON)'s stay at (HOSPITAL) that began on (ADMIT DATE)/(PERSON)'s visit to (PROVIDER) on (VISIT DATE)/the last purchase of {NAME OF PRESCRIBED MEDICINE...} for (PERSON)/the services for (FLAT FEE GROUP) for (PERSON)/the {OME ITEM GROUP NAME.....} used by (PERSON) since (START DATE)/services received at home from (PROVIDER) during (MONTH) for (PERSON)} exceed the charge I have recorded by {$ DISCREPANCY}. Let me be sure I have all the information recorded correctly.

REVIEW CHARGES AND PAYMENTS WITH RESPONDENT. WORK WITH RESPONDENT TO CORRECT ERRONEOUS INFORMATION, IF ANY.

IF TOTAL CHARGE NEEDS CORRECTION, JUMPBACK TO CP09.
TO MOVE CURSOR, USE ARROW KEYS. TO LEAVE, PRESS ESC.

OVERPAYMENT: {$XXXXXXXXX} TOTAL CHARGE: {$XXXXXXXXX}

ROSTER. SOURCE OF PAYMENT	CP26_02. DOLLAR AMOUNT PAID	CP26_03. PERCENT AMOUNT PAID
PERSON/Family	[Display $ Amount]	[Display % Amount]
[Display Source of Payment]	[Display $ Amount]	[Display % Amount]
[Display Source of Payment]	[Enter $ Amount]	[Enter % Amount]

ROSTER DEFINITION: THIS ITEM DISPLAYS ALL SOURCES ON THE EVENT'S-SOURCES-OF-PAYMENT-ROSTER THAT ARE FLAGGED AS 'DIRECT PAYMENT' AND THE ASSOCIATED DIRECT PAYMENT AMOUNTS.

TOTAL CHARGE: DISPLAY AMOUNT ENTERED AT CP09.

DISPLAY 'PERSON/FAMILY' AS THE FIRST SOURCE OF PAYMENT. IF THE AMOUNT PAID BY PERSON/FAMILY WAS ADJUSTED AT CP13, DISPLAY ADJUSTED AMOUNT. IF AMOUNT PAID BY PERSON/FAMILY WAS NOT ADJUSTED, DISPLAY THE RESPONSE TO CP11 IN THE 'AMOUNT PAID' COLUMN FOR PERSON/FAMILY. THAT IS, IF THE RESPONSE TO CP11OV1 IS AN AMOUNT, DISPLAY THE DOLLAR AMOUNT IN CP26_02, 'DOLLAR AMOUNT PAID'. IF THE RESPONSE TO CP11OV2 IS A PERCENTAGE, DISPLAY THE PERCENTAGE AMOUNT IN CP26_03, 'PERCENT AMOUNT PAID'. IF CP11OV1 OR CP11OV2 IS CODED '-8' (DON'T KNOW), DISPLAY 'DK' FOR THE AMOUNT IN BOTH CP26_02 AND CP26_03. IF CP11OV1 OR CP11OV2 IS CODED '-7' (REFUSED), DISPLAY 'REF' FOR THE AMOUNT IN BOTH CP26_02 AND CP26_03.

FLAG ALL SOURCES AND ASSOCIATED AMOUNTS AS 'DIRECT PAYMENTS'.

NOTE: **FEATURES OF THE SOURCE OF PAYMENT MATRIX.** 1. THIS MATRIX WILL WORK JUST LIKE THE SOURCE OF PAYMENT MATRIX AT CP13. HOWEVER IN THIS FIRST STAGE RESOLUTION PROCESS, ONLY CORRECTIONS TO DIRECT PAYMENTS CAN BE MADE. AS WELL, ONLY NEW SOURCES OF DIRECT PAYMENTS MAY BE ADDED. AT NO TIME IN THIS FIRST STAGE RESOLUTION PROCESS CAN ANY CORRECTIONS OR UPDATES BE MADE TO SOURCE NAMES OR AMOUNTS OF REIMBURSEMENTS.

CP26OV
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DID ANY OTHER SOURCES MAKE ANY PAYMENTS DIRECTLY TO THE PROVIDER?

YES 1
NO 2

PRESS F1 FOR A DEFINITION OF PAYMENTS MADE DIRECTLY TO PROVIDER.

END_LP04
========

IF CP26OV IS CODED '1' (YES), CYCLE TO COLLECT ADDITIONAL SOURCES OF PAYMENT

IF CP26OV IS CODED '2' (NO), END LOOP_04 AND CONTINUE WITH BOX_15

BOX_15
======

RECALCULATE AMOUNT OF UNDERPAYMENT OR OVERPAYMENT.

IF UNDERPAYMENT IS > 3% OR $5 (WHICHEVER IS HIGHER) OF TOTAL CHARGE, CONTINUE WITH BOX_19

OTHERWISE, GO TO CP37

BOX_16
======

OMITTED.

CP27
====

OMITTED.

CP28
====

OMITTED.

CP28OV1
=======

OMITTED.

CP28OV2
=======

OMITTED.

BOX_17
======

OMITTED.

BOX_18
======

OMITTED.

CP29
====

OMITTED.

CP30
====

OMITTED.

CP30OV1
=======

OMITTED.

CP30OV2
=======

OMITTED.

BOX_19
======

| IF CP21 WAS ASKED, GO TO CP37 |

| OTHERWISE, CONTINUE WITH BOX_20 |

BOX_20
======

| IF UNDERPAYMENT IS STILL > 3% OR $5 (WHICHEVER IS HIGHER) OF TOTAL CHARGE, CONTINUE WITH CP31 USING THE DIFFERENCE IN THE DISPLAY. |

| IF UNDERPAYMENT IS NOT > 3% OR $5 (WHICHEVER IS HIGHER) OF THE TOTAL CHARGE, GO TO CP37 |

CP31
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}
{NAME OF PRESCRIBED MEDICINE...} {OME ITEM GROUP NAME...}

TO SCROLL, USE ARROW KEYS.
TO LEAVE BOX AND GO TO ENTRY FIELD, PRESS ESC.

ROSTER. SOURCE OF PAYMENT	DOLLAR AMOUNT PAID	PERCENT AMOUNT PAID
PERSON/Family	[Display $ Amount]	[Display % Amount]
[Display Source of Payment]	[Display $ Amount]	[Display % Amount]
[Display Source of Payment]	[Display $ Amount]	[Display % Amount]

TOTAL CHARGE: {$XXXXXXXXX} DIFFERENCE: {$XXXXXXXXX}

Do you expect anyone in the family to pay any {amount/more}?

YES 1
NO ..... 2 {CP37}
REF ..... -7 {CP37}
DK ..... -8 {CP37}

ROSTER DEFINITION: THIS ITEM DISPLAYS ALL SOURCES ON THE EVENT'S-SOURCES-OF-PAYMENT-ROSTER THAT ARE FLAGGED AS 'DIRECT PAYMENT' AND THE ASSOCIATED DIRECT PAYMENT AMOUNTS.

SOURCE OF PAYMENT MATRIX IS READ ONLY.

DISPLAY 'AMOUNT' IF PERSON FAMILY PAYMENT IS $0/0%. DISPLAY 'MORE' IF PERSON/FAMILY PAYMENT IS **NOT** EQUAL TO $0/0%

CP32
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}
{NAME OF PRESCRIBED MEDICINE...} {OME ITEM GROUP NAME...}

How much do you expect anyone in the family to pay?

IS ANSWER IN DOLLARS OR PERCENT?

DOLLARS 1
PERCENT ..... 2 {CP32OV2}

[Code One]

CP32OV1
=======

ENTER DOLLARS:

[Enter $ Amount] ..... {CP37}
REF ..... -7 {CP37}
DK ..... -8 {CP37}

| SOFT RANGE CHECK: $0 - $10,000 |

CP32OV2
=======

ENTER PERCENT:

[Enter % Amount] ..... {CP37}
REF ..... -7 {CP37}
DK ..... -8 {CP37}

| SOFT RANGE CHECK: 1% - 100% |

BOX_21
======

OMITTED.

CP33
====

OMITTED.

CP34
====

OMITTED.

CP34OV1
=======

OMITTED.

CP34OV2
=======

OMITTED.

BOX_22
======

OMITTED.

CP35
====

OMITTED.

CP36
====

OMITTED.

CP37
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

INTERVIEWER: WHAT RECORDS WERE USED IN COMPLETING THE CHARGE/PAYMENT INFORMATION FOR {(PERSON)'S STAY AT (HOSPITAL) THAT BEGAN ON (ADMIT DATE)/VISIT TO (PROVIDER) ON (VISIT DATE)/THE VISITS FOR (FLAT FEE GROUP)/THE LAST PURCHASE OF {NAME OF PRESCRIBED MEDICINE...}/THE {OME ITEM GROUP NAME} USED BY (PERSON) SINCE (START DATE)/SERVICES RECEIVED AT HOME FROM (PROVIDER) DURING (MONTH) FOR (PERSON)}?

CODE ALL THAT APPLY

RESPONDENT'S/FAMILY MEMBER'S MEMORY 1
RESPONDENT'S/FAMILY MEMBER'S CHECK BOOK ... 2
STATEMENT, BILL OR RECEIPT FROM
PROVIDER'S OFFICE 3
EXPLANATION OF BENEFITS FROM:
MEDICARE 4
PRIVATE INSURANCE CARRIER 5
CALENDAR 6
PRESCRIBED MEDICINE BOTTLE, BAG, OR
CONTAINER 7
OTHER 91

[Code All That Apply]

| IF CODED '91' (OTHER), ALONE OR IN COMBINATION WITH OTHER CODES, CONTINUE WITH CP37OV |

| OTHERWISE, GO TO BOX_23 |

CP37OV
======

ENTER OTHER:

[Enter Other Specify] .....

BOX_23
======

IF CP37 IS CODED '3' (PROVIDER'S OFFICE), '4' (EXPLANATION OF BENEFITS FROM MEDICARE), OR '5' (EXPLANATION OF BENEFITS FROM PRIVATE INSURANCE CARRIER) AND EVENT TYPE IS NOT PM OR OM, CONTINUE WITH CP38

OTHERWISE, GO TO BOX_24

CP38
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

INTERVIEWER: DOES THE PAPERWORK SHOW THAT (PROVIDER) HAS ANOTHER NAME?

YES 1
NO ..... 2 {BOX_24}

PRESS F1 FOR DEFINITION OF PROVIDER NAME.

CP39
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER.} {EV} {EVN-DT}
{REPEAT VISIT: {NAME OF REPEAT VISIT GROUP....}/FLAT FEE GROUP: {NAME OF FLAT FEE EVENT GROUP..}}

INTERVIEWER: ENTER OTHER NAME FOR (PROVIDER).

[Enter Medical-Provider-65]

BOX_24
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|  IF:                                                 |
|  EVENT-PROVIDER PAIR REPRESENTS A FLAT FEE GROUP,    |
|  OR                                                  |
|  EVENT TYPE IS PM, HS, OM, OR HH,                    |
|  OR                                                  |
|  PERSON-PROVIDER PAIR ALREADY FLAGGED AS 'COPAYMENT  |
|  SITUATION',                                         |
|  GO TO BOX_26                                        |
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|  OTHERWISE, CONTINUE WITH BOX_25                     |
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BOX_25
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|  IF [CP08 IS CODED '2' (NO), '-7' (REFUSED), OR      |
|  '-8' (DON'T KNOW)] OR [THE AMOUNT IN CP09 IS SET    |
|  TO THE COPAYMENT AMOUNT] OR [CP08 AND CP09 WERE     |
|  NOT ASKED AND CP06 IS CODED '5' (NO BILL SENT:      |
|  HMO PLAN), '6' (NO BILL SENT: VA), OR '8' (NO BILL  |
|  SENT: PUBLIC ASSISTANCE/MEDICAID/SCHIP)]            |
|  AND                                                 |
|  CP10 IS CODED '1' (YES)                             |
|  AND                                                 |
|  CP11 IS CODED '1' (DOLLARS) AND A WHOLE DOLLAR      |
|  AMOUNT GREATER (>) THAN $0 AND LESS THAN OR EQUAL   |
|  (<=) TO $50 IS ENTERED IN CP11OV1,                  |
|  FLAG THIS PERSON-PROVIDER PAIR AS A 'COPAYMENT      |
|  SITUATION', THEN CONTINUE WITH BOX_26               |
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|  OTHERWISE, DO NOT SET ANY FLAGS AND THEN CONTINUE   |
|  WITH BOX_26                                         |
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BOX_26
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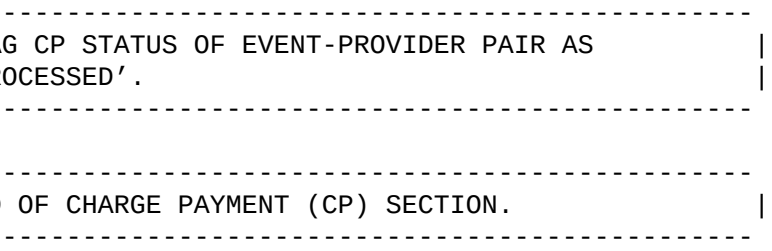
FLAG CP STATUS OF EVENT-PROVIDER PAIR AS
'PROCESSED'.
END OF CHARGE PAYMENT (CP) SECTION.