MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

EVENT FORM

FOR

INSTITUTIONAL PROVIDERS

(NON-HOSPITAL FACILITIES)

FOR

REFERENCE YEAR 2017

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

MEDICAL RECORDS – EVENT DATE

A1. WHAT WERE THE ADMIT AND DISCHARGE DATES OF THE (FIRST/NEXT) STAY?

REFERENCE PERIOD – CALENDAR YEAR 2017

ADMIT:

Month:_____
Day:_____
Year:_____

DISCHARGE:

Month:_____
Day:_____
Year:_____

NOT YET DISCHARGED..... 1

MEDICAL RECORDS – DIAGNOSES

A3. I need the diagnoses for this stay. I would prefer the ICD-10 codes, or the DSM-5 codes, if they are available.

IF CODES ARE NOT USED, RECORD DESCRIPTIONS.

[SYSTEM WILL ALLOW FOR A MAXIMUM OF 5 ICD-10 CODES TO BE COLLECTED.]

MEDICAL RECORDS – SBD

A2. I need to record the name and specialty of each physician who provided services during the stay starting on (ADMIT DATE) and whose charges might not be included in the facility bill. We are interested in physicians with whom your facility has contractual arrangements, not the patient's private physician.

PROBE FOR MORE THAN ONE RADIOLOGIST, ANESTHESIOLOGIST, ETC. OR OTHER SEPARATELY BILLING MEDICAL PROFESSIONAL.

IF RESPONDENT IS UNSURE WHETHER A PARTICULAR DOCTOR'S CHARGES ARE INCLUDED IN THE INSTITUTION BILL, RECORD YES HERE.

1. YES, SEPARATELY BILLING DOCTORS FOR THIS EVENT (1)
2. NO SEPARATELY BILLING DOCTORS FOR THIS STAY (2)
3. DO NOT HAVE THIS INFORMATION (3)

If A2 = 1, the system will automatically generate an SBD form at that time to be filled out with MR.

[IF A2=2, 3, or DK/REF/RETRIEVABLE – SKIP TO A4a
IF A2=YES, ASK EF1]

MEDICAL RECORDS – SBD SUBROUTINE

EF1. Can you please provide the full name of the (first/next) physician whose charges might not be included in the hospital bill?

GROUP NAME: _____
PREFIX: _____
FIRST: _____
MIDDLE:_____
LAST:_____
NATIONAL PROVIDER ID:_____

EF3. What is this physician's specialty?

Specialty: _____
If other, please specify: _____

EF2. Did this doctor provide any of the following services for this event: radiology, anesthesiology, pathology, or surgery?

1. Radiology
2. Anesthesiology
3. Pathology
4. Surgery
5. None of the above
6. DON'T KNOW

EF5. How would you describe the role of this doctor for this medical event?

Active Physician/Providing Direct Care (1)
Referring Physician (2)
Copied Physician (3)
Follow-up Physician (4)
Department Head (5)
Primary Care Physician (6)
Some Other Physician (7)
None of the above (8)
Don't Know (9)

(IF OTHER DESCRIBE) What other type of physician?:_____

EF6. ENTER ANY COMMENTS ABOUT THIS SBD INCLUDING ADDITIONAL SERVICE(S) TO THE ONE SELECTED IN EF2

SBDPR1: A diagnosis that you mentioned often involves a [FILL SPECIALTY] and we did not record such persons in the earlier questions about separately billing doctors. Do your records indicate that a [FILL SPECIALTY] was associated with this patient event?

YES (1)

NO (2)

IF SBDPR1=YES, RETURN USER TO A2
If SBDPR1=NO, ASK SBDPR3

SBDPR3: PROBE WHY THERE WAS NO SBD OF THE EXPECTED TYPES FOR THIS EVENT.

PATIENT ACCOUNTS – REIMBURSEMENT TYPE

Q5. Was the facility reimbursed for this stay on a fee-for-service basis or capitated basis?

EXPLAIN IF NECESSARY:

Fee-for-service means that the practice was reimbursed on the basis of the services provided.

Capitated basis means that the patient was enrolled in a prepaid managed care plan, such as an HMO, and reimbursement to the facility was not based on the services provided. This is also called Per Member Per Month

IF IN DOUBT, CODE FEE-FOR-SERVICE

FEE-FOR-SERVICE BASIS (1)
CAPITATED BASIS. (2 - go to Q21a)

IF Q5 =1 GO TO Q6_1
IF Q5=2 GO TO Q21a
DK/REF/RETRIEVABLE – CONTINUE TO Q6_1

PATIENT ACCOUNTS – SERVICES/CHARGES

Q6_1. DID [PATIENT] HAVE ANY HEALTH-RELATED ANCILLARY CHARGES FOR THIS STAY? THAT IS, WERE THERE CHARGES FOR ADDITIONAL SERVICES NOT INCLUDED IN THE BASIC RATE?

1. YES
2. NO

IF Q6_1 = 2 (NO); GO TO Q6
IF Q6_1 = 1 (YES), DK, OR RF; GO TO Q6_2

Q6_2. CAN YOU SEPARATE PAYMENTS FOR ANCILLARY SERVICES FROM PAYMENTS FOR ROOM/BOARD/BASIC CARE?

1. YES

2. NO
3. NO, ANCILLARY CHARGES WERE ADJUSTED 100%

IF Q6_2 = 1 (YES), DK, RF; GO TO Q6
IF Q6_2 = 2 OR 3, GO TO Q6 (WITH ADDITION OF "ANCILLARY CHARGES" TO QUESTION WORDING)

Q6. What was the **full established charge** for room, board, and basic care for this stay, before any adjustments or discounts, between (ADMIT DATE) and (DISCHARGE DATE/END OF 2017)?

EXPLAIN IF NECESSARY: The **full established charge** is the charge maintained in the facility's master fee schedule for billing private pay patients. It is the "list price" for the service, before consideration of any discounts or adjustments resulting from contractual arrangements or agreements with insurance plans.

IF NO CHARGE: Some facilities that don't charge for each individual service do associate dollar amounts with services in their records for purposes of budgeting or cost analysis. This kind of information is sometimes call a "**charge equivalent"**. Could you give me the charge equivalent for this stay?

NOTE: WE NEVER ENTER $0 FOR A CHARGE

$_____.____

CHECKPOINT: HAVE YOU BEEN ABLE TO DETERMINE THE FULL ESTABLISHED CHARGE?

YES, DID PROVIDE TOTAL CHARGE (1)
NO, CANNOT PROVIDE TOTAL CHARGE (2)

[If CHECKPOINT=1 go to Q7. If CHECKPOINT=2 go to Q10.]

Q6a: Why is there no charge for room, board, and basic care for this stay?

1. FACILITY ASSUMES COST
2. PREPAID TO CONTINUING CARE
3. STATE-FUNDED INDIGENT CARE (NOT MEDICAID)
4. RELIGIOUS ORGANIZATION ASSUMES COST
5. VA FACILITY
6. OTHER (SPECIFY)

After Q6a go to Q14

PATIENT ACCOUNTS – SOURCES OF PAYMENT

Q7. From which of the following sources has the facility received payment for this charge and how much was paid by each source? Please include all payments that have taken place between (ADMIT DATE) and now for this stay.

SELECT ALL THAT APPLY

[DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

[SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT REQUIRED]

OTHER SPECIFY: PROBE FOR SOURCE OF FUNDS AND TYPE OF PLAN.

IF PROVIDER VOLUNTEERS THAT PATIENT PAYS A MONTHLY PREMIUM, VERIFY: So, you receive a monthly payment rather than payment for the specific service? IF YES: GO BACK TO Q5 AND CODE AS CAPITATED BASIS

a. Patient or Patient's Family; .... $_____._____
b. Medicare; ..... $_____._____
c. Medicaid; ..... $_____._____
d. Private Insurance; ..... $_____._____
e. VA/Champva; ..... $_____._____
f. Tricare; ..... $_____._____
g. Worker's Comp; or ..... $_____._____
h. Something else?..... $_____._____
(IF SOMETHING ELSE: What was that? _____)

Q8. [I show the total payment as TOTPAYM / I show the payment as undetermined. / I show the payment as TOTPAYM, although one or more payments are missing] Is that correct?

IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS $_____._____

PATIENT ACCOUNTS – VERIFICATION OF PAYMENT

Q8a: I recorded that the payment(s) you received equal the charge(s). I would like to make sure that I have this recorded correctly. I recorded that the total payment is [SYSTEM WILL DISPLAY TOTAL PAYMENT FROM Q8]. Does this total payment include any other amounts such as adjustments or discounts, or is this the final payment?

IF NECESSARY, READ BACK AMOUNT(S) RECORDED IN Q7.

YES, FINAL PAYMENTS RECORDED IN Q7 AND Q8. (1 - GO TO Q14)
NO (2 - GO BACK TO Q7)

PAYMENTS LESS THAN CHARGES

PLC1: It appears that the total payments were less than the total charge. Is that because...

a. There were adjustments or discounts ..... YES=1 NO=2
b. You are expecting additional payment ... YES=1 NO=2
c. This was charity care or sliding scale ..... YES=1 NO=2
d. This was bad debt .....YES=1 NO=2
e. Person is an eligible veteran.....YES=1 NO=2

PATIENT ACCOUNTS – DIFFERENCE BETWEEN PAYMENTS AND CHARGES

Are you expecting additional payment from:

IF THE ONLY PAYMENT FOR THIS EVENT WAS A LUMP SUM, ANSWER "NO" TO ALL OPTIONS

Expecting additional payment

i. Patient or Patient's Family? ..... YES=1 NO=2
j. Medicare? ..... YES=1 NO=2
k. Medicaid? ..... YES=1 NO=2
l. Private Insurance? ..... YES=1 NO=2
m. VA/Champva? ..... YES=1 NO=2
n. Tricare? ..... YES=1 NO=2
o. Worker's Comp? ..... YES=1 NO=2
p. Something else ..... YES=1 NO=2
(IF SOMETHING ELSE: What was that? _____)

ADJEXTRA

It appears that the total payments were more than the total charges. Is that correct?

YES (1)
NO (2)

DCS: IF THE ANSWER IS "NO" PLEASE GO BACK TO C5 (VERIFY TOTAL PAYMENTS) TO RECONFIRM CHARGES AND PAYMENTS AS NEEDED

PATIENT ACCOUNTS – RATES/CHARGES

Q10: Can you tell me what the facility's full established daily rate for room and board and basic care [and ancillary charges] was during this stay?

$_____ . _____

RATE PROVIDED (1)
RATE CHANGED DURING STAY (2)

[If Q10=1 go to Q11.
If Q10=2 go to Q12.]

Q11: This stay for [PATIENT] that we are discussing lasted [STAYDAYS.] For how many days was the patient charged during this stay? Please give only the days during 2017.

_____ # DAYS

DAYS PROVIDED (1)
DAYS NOT REPORTED (2)

[IF RESPONDENT CAN'T PROVIDE TOTAL DAYS, GO TO Q12. ELSE GO TO Q11a.]

PATIENT ACCOUNTS – SOURCES OF PAYMENT 2

Q11a. From which of the following sources has the facility received payment for these charges and how much was paid by each source? Please include all payments that have taken place between (ADMIT DATE) and now for this stay.

SELECT ALL THAT APPLY

[DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

[SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT REQUIRED]

OTHER SPECIFY: PROBE FOR SOURCE OF FUNDS AND TYPE OF PLAN.

IF PROVIDER VOLUNTEERS THAT PATIENT PAYS A MONTHLY PREMIUM, VERIFY: So, you receive a monthly payment rather than payment for the specific service? IF YES: GO BACK TO Q5 AND CODE AS CAPITATED BASIS

a. Patient or Patient's Family; ..... $_____.____
b. Medicare; ..... $_____.____

c. Medicaid; ..... $_____.____
d. Private Insurance; ..... $_____.____
e. VA/Champva; ..... $_____.____
f. Tricare; ..... $_____.____
g. Worker's Comp; ..... $_____.____
h. Something else?..... $_____.____
(IF SOMETHING ELSE: What was that? _____)

Q11b. [I show the total payment as TOTPAYM / I show the payment as undetermined. / I show the payment as TOTPAYM, although one or more payments are missing] . Is that correct?
IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS

[If Q11b=1 go to Q14.
If Q11b=2 go to Q11a.

Q11a - DK/REF/RETRIEVABLE – CONTINUE TO Q11b.
Q11b - DK/REF/RETRIEVABLE – CONTINUE TO Q14.]

PATIENT ACCOUNTS – BILLING PERIOD INFORMATION WITH PAYMENTS

Q12. (Perhaps it would be easier if you gave me information about payments by billing period.) What was the billing start date?

Month: _____
Day: _____
Year: _____

Q12a. What was your billing end date?

Month: _____
Day: _____
Year: _____

Q12-1. BILLING PERIOD IS BETWEEN M#/ D#/ Y# and M#/D#/ Y# Thanks, that means there were (#) days in your billing period. Between (M#/ D#/ Y# and M#/D#/ Y#), how many days was the patient charged for room, board and basic care, [and ancillary charges]?

_____# BILLED DAYS

[IF #BILLED DAYS IS LESS THAN TOTAL DAYS IN STAY from Q12 and Q12a, go to Q12-1a else go to Q12-2.]

Q12-1a. The number of days the patient was charged for room, board and basic care, and ancillary charges was (Q12-1) days and that is less than the number of days in the billing period, (TOTAL DAYS IN STAY). Do you know why?

_____

Q12-2. Between (M#/ D#/ Y# and M#/D#/ Y#), what was the private pay rate for room, board and basic care, [and ancillary charges] (PATIENT NAME) received? If the rate changed, please give me the initial rate.

$_____.____

12-3. How many days was that rate applied during this billing period?

_____ # DAYS

[Q12-3: If **Q12-2** is less than **Q12-3** go to Q12-Intro, else record Q12-2 in Q12-8 and continue to Q13.]

12-Intro. I see that the rate of (**Q12-2**) applied for (**Q12-3**) days, although your billing period was (Q12-1) long. I need to ask some questions to help account for the entire billing period.

12-2A. Between (M#/ D#/ Y# and M#/D#/ Y#), what other private pay rate applied to the basic care that (PATIENT NAME) received?

$_____.____

12-3A. On what date did this rate of (**12-2A**) begin?

Month: _____
Day: _____
Year: _____

12-4A. During this billing period, how many days was that rate of (**12-2A**) applied?

DAYS: _____

12-5A. Why did the rate change? CODE ONLY ONE.

LEVEL OF CARE (1)
PATIENT DISCHARGED TO HOSPITAL (2)

PATIENT DISCHARGED TO COMMUNITY (3)
PATIENT DISCHARGED TO OTHER FACILITY (4)
RATE INCREASE (5)
ROOM CHANGE (6)
OTHER, SPECIFY (7) _____

[Q12-5A: If **[Q12-1]** is more than [**12-3 + 12-4a**] ask Q12-2A to Q12-5A, else go to Q12-7. This means that we should administer Q12-A to Q12-5A until we "get up to" the end-of-billing period reported in Q12a.]

12-7. Is (RATE IN 12-2a) the private pay rate that applied at the end of the billing period?

YES (1)
NO (2)

[If Q12-7=1 skip to 12-9.
If Q12-7=2 continue to Q12-8 and record rate at end of billing period.]

12-8. What was the private pay rate that applied at the end of the billing period?

$_____.____

PATIENT ACCOUNTS – SOURCES OF PAYMENT 3

Q13. From which of the following sources did the facility receive payments for this billing period and how much was paid by each source? Please include all payments that have taken place between (ADMIT DATE) and now for this stay.

SELECT ALL THAT APPLY

[DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

[SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT REQUIRED]

OTHER SPECIFY: PROBE FOR SOURCE OF FUNDS AND TYPE OF PLAN.

IF PROVIDER VOLUNTEERS THAT PATIENT PAYS A MONTHLY PREMIUM, VERIFY: So, you receive a monthly payment rather than payment for the specific service? IF YES: GO BACK TO Q5 AND CODE AS CAPITATED BASIS

a. Patient or Patient's Family; ..... $_____.____
b. Medicare; ..... $_____.____
c. Medicaid; ..... $_____.____

d. Private Insurance; ..... $_____.____
e. VA/Champva; ..... $_____.____
f. Tricare; ..... $_____.____
g. Worker's Comp; ..... $_____.____
h. Something else?..... $_____.____
(IF SOMETHING ELSE: What was that? _____)

Q13a. [I show the total payment as TOTPAYM / I show the payment as undetermined. / I show the payment as TOTPAYM, although one or more payments are missing] IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS

[Q13 - DK/REF/RETRIEVABLE – CONTINUE TO Q13a
Q13a - DK/REF/RETRIEVABLE – CONTINUE TO Q14]

PATIENT ACCOUNTS – ANCILLARY CHARGES

Q14. Did (PATIENT NAME) have any health-related ancillary charges for this stay? That is, were there charges for additional services not included in the basic rate?

YES (1)
NO (2)

[If Q14=1 go to Q15. If Q14=2 go to Q22.
Q14 - DK/REF/RETRIEVABLE – CONTINUE TO Q15]

PATIENT ACCOUNTS – TOTAL ANCILLARY CHARGES

Q15. What was the total of full established charges for health-related ancillary care during this stay? Please exclude charges for non-health related services such as television, beautician services, etc.

EXPLAIN IF NECESSARY: Ancillaries are facility charges that are not included in the basic charge. Ancillary charges may include laboratory, radiology, drugs and therapy (physical, speech, occupational).

TOTAL CHARGES: $_____.___

YES, PROVIDED (1)
CAN'T SEPARATE HEALTH AND NON-HEALTH ANCILLARY CHARGES (2)
CAN'T GIVE TOTAL HEALTH-RELATED ANCILLARY CHARGES (3)

IF NO CHARGE Some facilities that don't charge for each individual service do associate dollar amounts with services for purposes of budgeting or cost analysis. This is sometimes called a "charge equivalent". Could you give me the total of the charge equivalents for health-related ancillary care during this stay?

PATIENT ACCOUNTS – SOURCES OF PAYMENT 4

Q16. From which of the following sources has the facility received payment for these charges and how much was paid by each source? Please include all payments that have taken place between (ADMIT DATE) and now for this stay.
SELECT ALL THAT APPLY

[DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

[SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT REQUIRED]

OTHER SPECIFY: PROBE FOR SOURCE OF FUNDS AND TYPE OF PLAN.

a. Patient or Patient's Family; .... $_____.____
b. Medicare; ..... $_____.____
c. Medicaid; ..... $_____.____
d. Private Insurance; ..... $_____.____
e. VA/Champva; ..... $_____.____
f. Tricare; ..... $_____.____
g. Worker's Comp; ..... $_____.____
h. Something else?..... $_____.____
(IF SOMETHING ELSE: What was that? _____)

Q17. [I show the total payment as TOTPAYM / I show the payment as undetermined. / I show the payment as TOTPAYM, although one or more payments are missing] Is that correct? IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS $_____.___

BOX 2

DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?

1. YES, AND ALL PAID BY PATIENT OR PATIENT'S FAMILY (GO TO Exit)
2. YES, OTHER PAYERS (GO TO Q17a)
3. NO, PAYMENTS < CHARGES (GO TO PLC2)
4. NO, PAYMENTS > CHARGES (GO TO ADJEXTRA_2)

PATIENT ACCOUNTS – VERIFICATION OF PAYMENT 2

Q17a: I recorded that the payment(s) you received equal the charges. I would like to make sure that I have this recorded correctly. I recorded that the total payment is [SYSTEM WILL DISPLAY TOTAL PAYMENT FROM Q17]. Does this total payment include any other amounts such as adjustments or discounts, or is this the final payment?
IF NECESSARY, READ BACK AMOUNT(S) RECORDED IN Q16.

YES, FINAL PAYMENTS RECORDED IN Q16 AND Q17 (1)
NO (2)

PAYMENTS LESS THAN CHARGES

PLC2: It appears that the total payments were less than the total charge. Is that because...

a. There were adjustments or discounts ..... YES=1 NO=2
b. You are expecting additional payment ... YES=1 NO=2
c. This was charity care or sliding scale ..... YES=1 NO=2
d. This was bad debt .....YES=1 NO=2
e. Person is an eligible veteran..... YES=1 NO=2

PATIENT ACCOUNTS – DIFFERENCE BETWEEN PAYMENTS AND CHARGES

Are you expecting additional payment from:

IF THE ONLY PAYMENT FOR THIS EVENT WAS A LUMP SUM, ANSWER "NO" TO ALL OPTIONS

Expecting additional payment

i. Patient or Patient's Family? ..... YES=1 NO=2
j. Medicare? ..... YES=1 NO=2
k. Medicaid? ..... YES=1 NO=2
l. Private Insurance? ..... YES=1 NO=2
m. VA/Champva? ..... YES=1 NO=2

n. Tricare? ..... YES=1 NO=2
o. Worker's Comp? ..... YES=1 NO=2
p. Something else ..... YES=1 NO=2
(IF SOMETHING ELSE: What was that? _____)

ADJEXTRA_2
It appears that the total payments were more than the total charges. Is that correct?

YES=1, NO=2

DCS: IF THE ANSWER IS "NO" PLEASE GO BACK TO C5 (VERIFY TOTAL PAYMENTS) TO RECONFIRM CHARGES AND PAYMENTS AS NEEDED

PATIENT ACCOUNTS – BILLING PERIOD INFORMATION 2

Q19: Perhaps it would be easier if you gave me the information about ancillary charges by billing period.

a. First, what was the start date of the first billing period in which (PATIENT NAME) was a patient?
ENTER MONTH ONLY IF BILLING PERIOD IS MONTHLY.
(MONTH)
or
(START DATE)

b. And what was the end date? (END DATE)

c. What was the total of full established charges for health-related ancillary care during this billing period? Please exclude charges for non-health related services such as television, beautician services, etc. $_____.____

PATIENT ACCOUNTS – SOURCES OF PAYMENT 5

Q20. From which of the following sources did the facility receive payments for **ancillary charges** for the billing period that began (BILLING PERIOD DATE) and how much was paid by each source? Please include all payments that have taken place between (ADMIT DATE) and now for this stay.
SELECT ALL THAT APPLY

a. Patient or Patient's Family; .... $_____.____
b. Medicare; ..... $_____.____
c. Medicaid; ..... $_____.____

d. Private Insurance; ..... $_____.____
e. VA/Champva; ..... $_____.____
f. Tricare; ..... $_____.____
g. Worker's Comp; ..... $_____.____
h. Something else?..... $_____.____
(IF SOMETHING ELSE: What was that? _____)

Q20(h) – Menu for "Something else?":

- Auto or Accident Insurance
- Indian Health Service
- State Public Mental Plan
- State/County Local program
- Other

Q20a. [SYSTEM WILL GENERATE AFTER Q20 FOR EACH BILLING PERIOD IN Q19]

I show the total payment as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct?

IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

[Q20a=NO RETURN USER TO Q20, ELSE CONTINUE TO FINISH.
[Q20a - DK/REF/RETRIEVABLE NOT ALLOWABLE.]

PATIENT ACCOUNTS – CAPITATED BASIS

Q21a. What kind of insurance plan covered the patient for this stay? Was it:

[DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

OTHER SPECIFY: PROBE FOR SOURCE OF FUNDS AND TYPE OF PLAN.

a. Medicare? ..... YES=1 NO=2
b. Medicaid? ..... YES=1 NO=2
c. Private Insurance? ..... YES=1 NO=2
d. VA/Champva? ..... YES=1 NO=2
e. Tricare? ..... YES=1 NO=2
f. Worker's Comp? ..... YES=1 NO=2
g. Something else ..... YES=1 NO=2
(IF SOMETHING ELSE: What was that? _____)

Q21a(g) – Other Specify Menu:

- Auto or Accident Insurance

- Indian Health Service
- State Public Mental Plan
- State/County Local program
- Other

Q21b. What was the monthly payment from that plan?

$_____._____

Q21c. Was there a co-payment for any part of this stay?

YES (1)
NO (2 - GO TO **Q21e**)

Q21d. How much was the co-payment?

$_____._____

per

DAY (1)
WEEK (2)
MONTH (3)
OTHER (4)
SPECIFY: _____

Q21e. For how many (days/weeks/months/other) was the co-payment paid?

_____#

QC21f. Who paid the co-payment? Was it:

[DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

a. Patient or Patient's Family? .... YES=1, NO=2
b. Medicare? ..... YES=1, NO=2
c. Medicaid? ..... YES=1, NO=2
d. Private Insurance? ..... YES=1, NO=2
e. Something else? ..... YES=1, NO=2
   (IF SOMETHING ELSE: What was that?)

Q21f(e) – Include the following options in a drop down menu for the “Other Specify”:

- Auto or Accident Insurance
- Indian Health Service
- State Public Mental Plan
- State/County Local program

- Other

Q21g. Do your records show any other payments for this stay?

YES (1)
NO (2)

Q21h. From which of the following other sources has the facility received payment for this stay and how much was paid by each source? Please include all payments that have taken place between (ADMIT DATE) and now for this stay.

SELECT ALL THAT APPLY

[DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

OTHER SPECIFY: **PROBE FOR SOURCE OF FUNDS AND TYPE OF PLAN.**

a. Patient or Patient's Family; .... $_____.____
b. Medicare; ..... $_____.____
c. Medicaid; ..... $_____.____
d. Private Insurance; ..... $_____.____
e. VA/Champva; ..... $_____.____
f. Tricare; ..... $_____.____
g. Worker's Comp; ..... $_____.____
h. Something else?..... $_____.____
(IF SOMETHING ELSE: What was that? _____)

21h (h) – Include the following options in a drop down menu for the “Other Specify”;

- Auto or Accident Insurance
- Indian Health Service
- State Public Mental Plan
- State/County Local program
- Other

FINISH SCREEN

PRESS VALIDATE TO COMPLETE THIS EVENT FORM.