

MEDICAL EXPENDITURE PANEL SURVEY MEDICAL PROVIDER COMPONENT EVENT FORM

**FOR
PHARMACIES
FOR
REFERENCE YEAR 2024**

OMB

OMB Statement

This survey is authorized under 42 U.S.C. 299a. This information collection is voluntary and the confidentiality of your responses to this survey is protected by Sections 944(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)]. Information that could identify you will not be disclosed unless you have consented to that disclosure. 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. The data you provide will help AHRQ's mission to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable. 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 (OMB control number 0935-0118) AHRQ, 5600 Fishers Lane, Room #07W42, Rockville, MD 20857, or by email at REPORTSCLEARANCEOFFICER@ahrq.hhs.gov.

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 TO Q3A***

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 TO Q2c/d
Q2c/d - DK/REF – CONTINUE TO Q2e
Q2e - DK/REF – CONTINUE TO Q3a/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 = 1

NO = 2

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?

Yes = 1

No = 2

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.