# Supporting Statement A

# Attachment 6

# Physician Questionnaires

# PHYSICIAN FORM

Initial Notification of Death

OMB #0925-0414 Exp: 5/09



**-Affix label here-**

Member ID: ___ ___ ___ - ___ ___ ___ - ___

First Name _____ M.I. _____

Last Name _____

Contact date: ☐☐-☐☐-☐☐ (M/D/Y)

Completed by: ☐☐-☐☐☐

Contact type: ☐1 Phone ☐2 Mail ☐8 Other

1. **What is the date of death?** ☐☐ - ☐☐ - ☐☐ (M/D/Y)

2. Source of notification: ***(Mark one.)***

☐1 Family member

☐2 Friend/associate of deceased

☐3 Personal physician

☐4 NDI

☐8 Other _____

(CCC use only)

2.1. Name, address and phone number of the source.

Name: _____

Address: _____

_____

Phone Number: (____) _____

Provider ID ☐☐☐☐☐

3. **Did the death occur in a hospital/medical institution (i.e., hospital, long term care facility, hospice)?**

☐0 No ☐1 Yes ☐9 Unknown → **Go to Page 2.**

3.1. Name, address and phone number of the hospital/medical institution (i.e., hospital, long term care facility, hospice).

Hospital Name: _____

City/State: _____

Phone Number: (____) _____

Provider ID ☐☐☐☐☐

**Go to Page 2.**

3.2. Location and address of death, if death did not occur in a hospital/medical institution.

Location: _____

Address: _____

_____

RV_____ K_____ V_____

4. **Was an autopsy done?**

☐ 0 No ☐ 1 Yes

☐ 9 Unknown

4.1. Name, address and phone number where autopsy was performed.

Name: _____

Address: _____

_____

Phone Number: (____) _____

Provider ID

5. **Where will the death certificate be obtained?**

☐ 1 Coroner/Medical Examiner

☐ 2 Personal physician

☐ 3 Vital Statistics Office

☐ 8 Other ***(Specify):*** _____

☐ 9 Unknown

5.1. Name, address and phone number of individual providing the death certificate.

Name: _____

Address: _____

_____

Phone Number: (____) _____

Provider ID

6. (Ask of source): **To the best of your knowledge, what was the underlying cause of death?**

_____

_____

7. On the basis of currently available data, what was the underlying cause of death? ***(Mark one.)***

**Cancer**

☐ 1 Breast

☐ 2 Ovarian

☐ 3 Endometrial

☐ 4 Colon

☐ 5 Rectosigmoid junction

☐ 6 Rectum

☐ 7 Uterus

☐ 10 Lung

☐ 8 Other cancer

_____

☐ 9 Unknown cancer site

**Cardiovascular Disease**

☐ 11 Coronary Heart Disease (CHD)

☐ 12 Cerebrovascular disease

☐ 13 Pulmonary Embolism

☐ 18 Other cardiovascular disease

_____

☐ 19 Unknown cardiovascular disease

**Accident/Injury**

☐ 21 Homicide

☐ 22 Accident

☐ 23 Suicide

☐ 28 Other Injury _____

**"Other" Cause of Death**

☐ 31 Alzheimer's Disease

☐ 32 COPD

☐ 33 Pneumonia

☐ 34 Pulmonary Fibrosis

☐ 35 Renal Failure

☐ 36 Sepsis

☐ 88 Another cause of death, known

_____

☐ 99 Unknown cause of death