MEDICAL PROVIDER COMPONENT
FOR REFERENCE YEAR 2009

CONTACT GUIDE FOR HOSPITALS

VERSION 2.0

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FACILITY SCREENER

S0. [N/A] (ASK IF NOT OBVIOUS) Hello, have I reached (PROVIDER)?

S1. [S1] (ASK IF NOT OBVIOUS) (Hello,) is this a hospital, hospital outpatient department, hospital satellite clinic, surgi-center, or skilled nursing facility?

☐ YES .....1 (GO TO MR1)
☐ NO 2

S2. [S2] How would you describe this facility? Is this:

A hospital outpatient department, hospital satellite clinic, surgi-center, or skilled nursing facility? (GO TO MR1)

A doctor's office; ☐
A publicly-funded clinic; ☐
An urgent care center; ☐
A home care provider; ☐
A long term care facility such as a nursing home; or ☐
Something else? (SPECIFY:) _____ ☐
_____

} **TERMINATE CALL** & CODE APPROPRIATELY

MEDICAL RECORDS

MR1 [INTRODUCTION TO IDENTIFY A RESPONDENT]

May I please have the name and telephone number of the person who handles the release of medical records?

☐ SPEAKING TO PERSON WHO HANDLES RELEASE OF MEDICAL RECORDS → RECORD NAME AND VERIFY TELEPHONE NUMBER

(May I please have your name?) (IF ONLY FIRST NAME GIVEN PROBE FOR FULL NAME)

NAME: _____

The telephone number that I dialed is (FILL TELEPHONE NUMBER). Is that the best number at which to reach you?

TELEPHONE NUMBER: (_____) _____ EXT: _____

YES → CONTINUE WITH MR2
NO → MAKE CORRECTIONS AS NECESSARY, CONTINUE WITH MR2

☐ MEDICAL RECORDS DEPARTMENT CONTACT → RECORD NAME AND TELEPHONE NUMBER

NAME:_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

Will you please transfer me to them?

YES → CONTINUE WITH MR2

NO → TERMINATE CALL, CONTACT MEDICAL RECORDS DEPARTMENT, CONTINUE WITH MR2

☐ MEDICAL RECORDS ARE MAINTAINED BY AN OUTSIDE SERVICE → ASK TO SPEAK TO SOMEONE AT THE HOSPITAL WHO DEALS WITH THE OUTSIDE SERVICE → RECORD NAME AND TELEPHONE NUMBER

NAME:_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

Will you please transfer me to them?

YES → CONTINUE WITH MR2

NO → TERMINATE CALL, CONTACT PERSON WHO DEALS WITH MR SERVICE, CONTINUE WITH MR2

☐ NO MEDICAL RECORDS DEPARTMENT; NOT CLEAR WHO TO SPEAK TO → RECORD PROBLEM; TERMINATE CALL AND MARK FOR SUPERVISOR REVIEW

_____

MR2 [MR INTRODUCTION FOR RESPONDENT]

Hello, my name is (YOUR NAME) and I am calling on behalf of the U.S. Department of Health and Human Services. We are conducting MEPS which is a study about how people in the United States use and pay for health care.

MR2a. [N/A] CONTROL SYSTEM WILL FLAG WHETHER OR NOT THIS IS A CONTACT GROUP:

IF CONTACT GROUP..... 1 (GO TO MR2b)
IF NOT A CONTACT GROUP..... 2 (GO TO MR3)

MR2b. [N/A]

I need to determine if the following providers were associated with this organization during 2009. REVIEW EACH PROVIDER WITH THE CONTACT PERSON AND INDICATE WHETHER THE PROVIDER IS IN OR OUT OF THE CONTACT GROUP.

[CONTINUE WITH MR3 FOR PROVIDERS IN THE CONTACT GROUP. PROVIDERS WHO ARE NOT IN CONTACT GROUP WILL BE REMOVED FROM THIS GROUP AND TREATED SEPARATELY WITHIN THE SYSTEM.]

MR3 [MR INTRODUCTION FOR RESPONDENT]

[NUMBER FROM PATIENT LIST] patient(s) identified (FACILITY) as a source of health care during 2009. (The/Each) patient signed an authorization form allowing us to contact you for information about the care they received from (FACILITY) in 2009. Would you or someone in your office be able to provide this type of information?

IF ASKED READ PATIENT NAMES AND OTHER IDENTIFYING INFORMATION FROM THE PATIENT DATA FORM

YES ……1 (START WITH MR4)
NO ……2 (COLLECT INFORMATION BELOW)

Who should we contact to request medical records for each date of service received from (FACILITY) in 2009?

[IF CORRECT PERSON IS NOT KNOWN, PROBE FOR SOMEONE WHO WOULD KNOW.]

NAME:_____

TITLE:_____

DEPARTMENT:_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

Thank you very much for your help. [ASK TO BE TRANSFERRED OR PLACE CALL TO NEW CONTACT.]

IF UNABLE TO SEND AUTHORIZATION FORMS, GO TO PATIENT ACCOUNTS INTRODUCTION

MR4. [MR1] I would like to fax the authorization form(s) to your office along with additional information explaining the study.

IF ASKED READ PATIENT NAMES AND OTHER IDENTIFYING INFORMATION FROM THE PATIENT DATA FORM

[READ IF THE RESPONDENT WOULD LIKE TO PROVIDE THE DATA PRIOR TO RECEIVING AUTHORIZATION FORM(S)]: In order to remain HIPAA compliant, I need to send you the authorization form(s) before any data can be collected.

FAX AUTHORIZATION FORM(S)…….. 1 (GO TO MR5)
MAIL AUTHORIZATION FORM(S)…….. 2 (GO TO MR6)

DEPARTMENT DOES NOT HAVE ACCESS TO INFORMATION OR IT IS NOT AVAILABLE. EXPLAIN:

_____

_____

_____

THANK RESPONDENT AND TERMINATE CALL. MARK FOR SUPERVISOR REVIEW.

MR5. [MR2] I need to be sure I have the correct information for the fax cover page.
Should I address this fax to you?

YES → What is the fax number I can use to send you the authorization form(s)?

FAX NUMBER: (_____)_____

Can I also have your title and department?

TITLE: _____
DEPARTMENT:_____

GO TO MR7

NO → Please tell me to whom I should fax this information.

NAME: _____
TITLE:_____
DEPARTMENT:_____
FAX NUMBER: (_____)_____
TELEPHONE NUMBER: (_____)_____ EXT: _____

GO TO MR7

MR6. [MR3] I need to make sure that I have the correct mailing information.
Should I address the package to you?

YES → What is the mailing address that I can use to send you the authorization form(s)?

TITLE:_____
DEPARTMENT:_____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____

NO→ Can I have that person's information to mail the authorization form(s)?

NAME: _____
TITLE:_____
DEPARTMENT:_____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: (_____)_____ EXT: _____

MR7. [MR4] Once you have received the authorization form(s), we will call back to collect the data over the phone. We are requesting information about diagnoses and the names of the providers who treated each patient for each date of service in 2009.

MR8. [MR5] What would be the best day and time to call?

DAY:_____ DATE:_____ R's TIME:_____ AM/PM

IF PROVIDER DOESN'T WANT TO PROVIDE DATA OVER THE PHONE, OFFER FAX OR MAIL

You can send us the medical records by either fax or mail.

BY PHONE..... 1
BY FAX..... 2
BY MAIL..... 3

IF POINT OF CONTACT (POC) WILL RESPOND BY PHONE READ:
Thank you very much. We will allow time for you to receive and review the authorization form(s), and then we will call you back to collect the data.

IF POC WILL RESPOND BY FAX OR MAIL READ:
We hope you can send the records to our office within two weeks. We will include an instruction sheet when we (fax/mail) the authorization form(s). If you have any questions about what to send us, please call our toll-free number on the

instruction sheet. We may call again if other patients identify this practice as a source of medical services. Thank you very much for your help.

HAS A FAX BEEN SENT TO PA?:

YES .....1 (GO TO MR11)
NO .....2 (GO TO MR9)

MR9. [MR6] We are also interested in the charges and the summary of payments for each date of service in 2009. Can you provide this information?

YES, MEDICAL RECORDS CAN PROVIDE INFO……1 (GO TO MR11)
NO, CONTACT OTHER DEPARTMENT……2 (GO TO MR10)

MR10. [MR7] Can you please provide the name, title, department, and telephone number of whom we should contact to obtain this information?

NAME: _____
TITLE:_____
DEPARTMENT:_____
TELEPHONE NUMBER: (_____)_____ EXT: _____

Thank you for that information.

MR11. [MR8] We are interested in collecting the names and locating information for the providers who treated each patient while they received services in this facility in 2009. Can you provide this information, too?

YES, MEDICAL RECORDS CAN PROVIDE INFO.....1 (GO TO MR13)
NO, CONTACT OTHER DEPARTMENT…….. 2 (GO TO MR12)

MR12. [MR9] Can you please provide the name, title, department, and telephone number of whom we should contact to obtain this information?

NAME: _____
TITLE:_____
DEPARTMENT:_____
TELEPHONE NUMBER: (_____)_____ EXT: _____

MR13. [N/A]_ Thank you very much for your help. We may call again if other patients identify this facility as a source of medical services.

[IF PA HAS NOT BEEN CONTACTED: Can you transfer me to Patient Accounts? In case we are cut off, can you give me the name and telephone number of the person to contact?]

NAME: _____
TELEPHONE NUMBER: (_____)_____ EXT: _____

PATIENT ACCOUNTS/BILLING SERVICE

[START HERE IF NO RESPONSE FROM MR10]

PA1. [INTRODUCTION TO IDENTIFY A RESPONDENT]

May I please speak to a person who handles the release of Patient (Billing/Accounts)?

☐ SPEAKING TO PERSON WHO HANDLES RELEASE OF PATIENT BILLIING → RECORD NAME AND VERIFY TELEPHONE NUMBER

(May I please have your name?) (IF ONLY FIRST NAME GIVEN PROBE FOR FULL NAME)

NAME:_____

The telephone number that I dialed is (FILL TELEPHONE NUMBER). Is that the best number at which to reach you?

TELEPHONE NUMBER: (_____)_____ EXT: _____

YES → CONTINUE WITH PA2
NO → MAKE CORRECTIONS AS NECESSARY, CONTINUE WITH PA2

☐ PATIENT (BILLING/ACCOUNTS) DEPARTMENT CONTACT → RECORD NAME AND TELEPHONE NUMBER

NAME:_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

Will you please transfer me to them?

YES → CONTINUE WITH PA2

NO → TERMINATE INITIAL CALL, CONTACT MANAGER OF PATIENT (BILLING/ACCOUNTS) DEPARTMENT, CONTINUE WITH PA2

☐ PATIENT (BILLING/ACCOUNTS) IS PERFORMED BY AN OUTSIDE SERVICE → ASK TO SPEAK TO SOMEONE WHO DEALS WITH THE OUTSIDE SERVICE → RECORD NAME AND TELEPHONE NUMBER

NAME:_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

Will you please transfer me to them?

YES → CONTINUE WITH PA2

NO → TERMINATE INITIAL CALL, CONTACT PERSON WHO DEALS WITH OUTSIDE SERVICE, CONTINUE WITH PA2

☐ UNABLE TO OBTAIN PATIENT (BILLING/ACCOUNTS) DEPARTMENT; NOT CLEAR WHO TO SPEAK TO → RECORD PROBLEM; TERMINATE CALL AND MARK FOR SUPERVISOR REVIEW

[START HERE IF HAVE RESPONSE FROM MR10]

PA2 [INTRODUCTION FOR RESPONDENT]

Hello, my name is (YOUR NAME) and I am calling on behalf of the U.S. Department of Health and Human Services. We are conducting MEPS which is a study about how people in the United States use and pay for health care. [IF CALL WAS TRANSFERRED OR NAME OF RESPONDENT IS KNOWN: We were referred to you by (MR CONTACT) in medical records.]

[NUMBER FROM PATIENT LIST] patient(s) identified (FACILITY) as a source of health care during 2009. (The/Each) patient signed an authorization form allowing us to contact you for information about the care they received from (FACILITY) in 2009. For each date of service we are asking for the charges and the summary of payments. Would you or someone in your office be able to provide this type of information?

IF ASKED READ PATIENT NAMES AND OTHER IDENTIFYING INFORMATION FROM THE PATIENT DATA FORM

YES ……1 (START WITH PA3)
NO ……2 (COLLECT INFORMATION BELOW)

Who should we contact to obtain information about the charges and summary of payments for services provided from (FACILITY) in 2009?

[IF CORRECT PERSON IS NOT KNOWN, PROBE FOR SOMEONE WHO WOULD KNOW.]

NAME: _____
TITLE:_____
DEPARTMENT:_____
TELEPHONE NUMBER: (_____)_____ EXT: _____

Thank you very much for your help. [ASK TO BE TRANSFERRED OR PLACE CALL TO NEW CONTACT.]

IF FAX OR MAILOUT OF AUTHORIZATION FORM(S) TO MR IS CONFIRMED IN SYSTEM AND WE KNOW MR HAS RECEIVED THE AUTHORIZATION FORMS FROM F1, GO TO PA8.

IF AUTHORIZATION FORMS HAVE BEEN SENT TO MR, BUT NOT YET RECEIVED BY MR, GO TO PA3.

PA3. [PA1] I would like to fax the authorization form(s) to your office along with additional information explaining the study.

IF ASKED READ PATIENT NAMES AND OTHER IDENTIFYING INFORMATION FROM THE PATIENT DATA FORM

[READ IF THE RESPONDENT WOULD LIKE TO PROVIDE THE DATA PRIOR TO RECEIVING AUTHORIZATION FORM(S)]: In order to remain HIPAA compliant, I need to send you the authorization form(s) before any data can be collected.

[IF PA CONTACT REPORTS THAT MR RECEIVED AUTHORIZATION FORM(S), IT IS NOT NECESSARY TO SEND FORM(S) AGAIN, UNLESS REQUESTED BY PATIENT ACCOUNTS, GO TO PA8.]

FAX AUTHORIZATION FORM(S)…….. 1 (GO TO PA4)
MAIL AUTHORIZATION FORM(S)…….. 2 (GO TO PA5)

DEPARTMENT DOES NOT HAVE ACCESS TO INFORMATION OR IT IS NOT AVAILABLE. EXPLAIN: _____

THANK RESPONDENT AND TERMINATE CALL. MARK FOR SUPERVISOR REVIEW.

PA4. [PA2] I need to be sure I have the correct information for the fax cover page.
Should I address this fax to you?

YES → What is the fax number I can use to send you the authorization form(s)?

FAX NUMBER: (_____)_____

Can I also have your title and department?

TITLE: _____

DEPARTMENT:_____

GO TO PA6

NO → Please tell me to whom I should fax this information.

NAME:_____

TITLE:_____

DEPARTMENT:_____

FAX NUMBER: (_____)_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

GO TO PA6

PA5. [PA3] I need to make sure that I have the correct mailing information.
Should I address the package to you?

YES → What is the mailing address that I can use to send you the authorization form(s)?

TITLE:_____

DEPARTMENT:_____

ADDRESS: _____

_____

CITY: _____ STATE: _____ ZIP: _____

NO→ Can I have that person's information to mail the authorization form(s)?

NAME:_____

TITLE:_____

DEPARTMENT:_____

ADDRESS: _____

_____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: (_____)_____ EXT: _____

PA6. [PA4] Once you have received the authorization form(s) and the other study information, we will call back to collect the data. You will see that for each patient we are requesting the charges and the summary of payments for each date of service from (FACILITY) in 2009.

PA7. [PA5] What would be the best day and time to call?

DAY:_____ DATE:_____ R's TIME:_____ AM/PM

IF PATIENT ACCOUNTS DOESN'T WANT TO PROVIDE DATA OVER THE PHONE, OFFER FAX OR MAIL

You can send us the medical records by either fax or mail.

PROVIDER WILL RESPOND:

BY PHONE..... 1
BY FAX..... 2
BY MAIL..... 3

IF PA WILL RESPOND BY PHONE READ:
Thank you very much. We will allow time for you to receive and review the authorization form(s), and then we will call you back to collect the data.

IF PA WILL RESPOND BY FAX OR MAIL READ:
We hope you can send the records to our office within two weeks. We will include an instruction sheet when we (fax/mail) the authorization form(s). If you have any questions about what to send us, please call our toll-free number on the instruction sheet. We may call again if other patients identify a practice associated with this billing service as a source of medical services. Thank you very much for your help.

GO TO MEDICAL RECORDS SECTION, UNLESS ALREADY COMPLETED.

PA8. [N/A] If it is convenient for you, we can just go ahead and complete the data forms together over the phone right now. I'd be happy to hold on while you get the information you need from your records.

WILL COMPLETE BY PHONE NOW..... 1 (GO TO EVENT FORM)
WILL COMPLETE BY PHONE IN THE FUTURE..... 2 (GO TO PA9)
PREFERS FAXING OR MAILING RECORDS..... 3 (GO TO PA10)

PA9. [N/A] What would be the best day and time to call you back?

DAY:_____ DATE:_____ R's TIME:_____ AM/PM

Thank you very much for your help.

PA10. [N/A] We hope you can send the records to our office within two weeks. We will include an instruction sheet when we (fax/mail) the authorization form(s). If you have any questions about what to send us, please call our toll-free number on the instruction sheet. We may call again if other patients identify this practice as a source of medical services. Thank you very much for your help.

FOLLOW-UP INTRODUCTION FOR BOTH MEDICAL RECORDS AND PATIENT

F1. [F1] May I please speak to (POC)?

Hello, my name is (YOUR NAME) and I am calling on behalf of the U.S. Department of Health and Human Services. We peviously spoke about the MEPS study. Did you receive the authorization form(s) we (faxed/mailed)?

YES …… (GO TO F2 IF MODE= PHONE; GO TO F4 IF MODE = FAX OR MAIL)
NO ..... (GO TO F5)

IF MODE = PHONE, ASK F2

F2. [F7] If it is convenient for you, we can just go ahead and complete the data forms together over the phone right now. I'd be happy to hold on while you get the information you need from your records.

WILL COMPLETE BY PHONE NOW..... 1 (GO TO EVENT FORM)
WILL COMPLETE BY PHONE IN THE FUTURE..... 2 (GO TO F3)

F3. [F6] What would be the best day and time to call?

DAY:_____ DATE:_____ R's TIME:_____ AM/PM

Thank you very much for your help.

IF MODE = FAX or MAIL, ASK F4

F4. [N/A] Our records indicate that you will (fax/mail) the records to us. We hope you can do so within two weeks. Thank you very much for your help.

F5. [F2] I'm sorry. Let me (re-fax/re-send) the authorization form(s) to you.

FAX AUTHORIZATION FORM(S)..... 1 (GO TO F6)
MAIL AUTHORIZATION FORM(S)..... 2 (GO TO F7)

IF ASKED READ PATIENT NAMES AND OTHER IDENTIFYING INFORMATION FROM THE PATIENT DATA FORM

[READ IF THE RESPONDENT WOULD LIKE TO PROVIDE THE DATA PRIOR TO RECEIVING AUTHORIZATION FORM(S)]: In order to remain HIPAA compliant, I need to send you the authorization form(s) first. Once you have received the form(s), then we can arrange for the collection of the data.

F6. [F3] IF FAXED PREVIOUSLY: Before I send the authorization form(s) again, I would like to verify the information to include on the fax cover page.
CONFIRM PRELOAD INFORMATION FOR MEDICAL RECORDS OR PATIENT ACCOUNTS

FAX NUMBER: (_____)_____

NAME:_____

TITLE:_____

DEPARTMENT:_____

PROVIDER:_____

We will call again to ensure that you received the authorization form(s). Thank you for your help.

IF MAILED PREVIOUSLY: I need to be sure I have the correct information for the fax cover page.
Should I address this fax to you?

YES → What is the fax number I can use to send you the authorization form(s)?

FAX NUMBER: (_____)_____

Can I also have your title and department?

TITLE: _____
DEPARTMENT:_____

NO → Please tell me to whom I should fax this information.

NAME:_____
TITLE:_____
DEPARTMENT:_____
FAX NUMBER: (_____)_____
TELEPHONE NUMBER: (_____)_____ EXT: _____

We will call again to ensure that you received the authorization form(s). Thank you for your help.

F7. [F4] IF MAILED PREVIOUSLY: Before I send the authorization form(s) again, I would like to verify the information on the mailing label.
CONFIRM PRELOAD INFORMATION FOR MEDICAL RECORDS OR PATIENT ACCOUNTS.

NAME:_____

TITLE:_____

DEPARTMENT:_____

PROVIDER NAME:_____

ADDRESS:_____

CITY: _____STATE: _____ZIP:_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

We will call again to ensure that you received the authorization form(s). Thank you for your help.

IF FAXED PREVIOUSLY: I need to make sure that I have the correct mailing information.
Should I address the package to you?

YES → What is the mailing address that I can use to send you the authorization form(s)?

TITLE:_____
DEPARTMENT:_____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____

NO→ Can I have that person's information to mail the authorization form(s)?

NAME:_____
TITLE:_____
DEPARTMENT:_____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: (_____)_____ EXT: _____

We will call again to ensure that you received the authorization form(s). Thank you for your help.

ADMINISTRATIVE OFFICE OR MEDICAL

[START HERE IF NO RESPONSE FROM MR11]
AO1. [INTRODUCTION TO IDENTIFY A RESPONDENT]

May I please speak to someone in the administrative office?

☐ SPEAKING TO PERSON IN ADMINISTRATIVE OFFICE → RECORD NAME AND VERIFY TELEPHONE NUMBER

(May I please have your name?) (IF ONLY FIRST NAME GIVEN PROBE FOR FULL NAME)

NAME: _____

The telephone number that I dialed is (FILL TELEPHONE NUMBER). Is that the best number at which to reach you?

TELEPHONE NUMBER: (_____) _____ EXT: _____

YES → CONTINUE WITH AO2
NO → MAKE CORRECTIONS AS NECESSARY, AND CONTINUE WITH AO2

☐ ADMINISTRATIVE OFFICE DEPARTMENT CONTACT → RECORD NAME AND TELEPHONE NUMBER

NAME:_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

Will you please transfer me to them?

YES → CONTINUE WITH AO2

NO → TERMINATE INITIAL CALL, CONTACT ADMINISTRATIVE OFFICE, AND CONTINUE WITH AO2

☐ UNABLE TO OBTAIN ADMINISTRATIVE OFFICE CONTACT INFORMATION; NOT CLEAR WHO TO SPEAK TO → RECORD PROBLEM; TERMINATE CALL AND MARK FOR SUPERVISOR REVIEW

[START HERE IF HAVE RESPONSE FROM MR11]
AO2. [INTRODUCTION FOR RESPONDENT]

Hello, my name is (YOUR NAME) and I am calling on behalf of the U.S. Department of Health and Human Services. We are conducting MEPS which is a study about how people in the United States use and pay for health care.

We were referred to you by (GATEKEEPER/MR CONTACT PERSON/PROVIDER) from medical records. Earlier, your medical records department gave us information about the care that some of our study patients received at your facility and the names of the providers of that care. Now we need locating information for those providers and whether the charges for their services would be included in the hospital's bill or billed separately by the provider.

AO3. [AO1] As I give you the names of the providers I have, can you tell me which ones' services were included in the hospital bill?

WILL COMPLETE BY PHONE NOW..... 1 (GO TO AO4)
WILL COMPLETE BY PHONE IN THE FUTURE..... 2 (GO TO AO6)
CANNOT PROVIDE THE INFORMATION..... 3 (GO TO AO5)

AO4. [AO2] REVIEW SBD LISTS [GENERATED FROM CONTROL SYSTEM].

INFORMATION PROVIDED FOR ALL SBDs LISTED..... 1
Thank you very much for your help.

INFORMATION NOT PROVIDED FOR ALL SBDs LISTED..... 2 (GO TO AO5)

AO5. [AO3] Please give me the name and telephone number of the person who can provide that information.

NAME:_____
TITLE:_____
DEPARTMENT:_____
TELEPHONE NUMBER: (_____)_____ EXT: _____

Thank you very much for your help.

AO6. [AO4] What would be the best day and time to call you back?

DAY:_____ DATE:_____ R's TIME:_____ AM/PM

Thank you very much for your help.

RECONTACT PROVIDER OFFICE [N/A]

CALL BACK INITIAL CONTACT FOR VERIFICATION / UPDATE OF INFORMATION INITIALLY PROVIDED.

INCORRECT CONTACT INFORMATION

Hello, may I speak to (POC)? This is (YOUR NAME) calling on behalf of the U.S. Department of Health and Human Services. We previously spoke about the MEPS study. Thank you for providing the contact information for (NAME FROM MR3/MR10/MR12/PA2). Unfortunately we were unable to locate (NAME FOR MR3/MR10/MR12/PA2) with the information you provided. Could you please verify the contact information we currently have for (NAME FROM MR3/MR10/MR12/PA2)?

NAME:_____
TITLE: _____
DEPARTMENT/BILLING SERVICE: _____
TELEPHONE:(_____)_____EXT:_____

SAME INFORMATION CONFIRMED – That is currently the information we have on file. Do you know of any other way we can get in touch with (NAME FROM MR3/MR10/MR12/PA2)?

YES → COLLECT OTHER CONTACT INFORMATION

NAME:_____
TITLE: _____
DEPARTMENT/BILLING SERVICE: _____
TELEPHONE:(_____)_____EXT:_____

NO → END CONTACT AND MARK FOR SUPERVISOR REVIEW

Thank you very much for your help.

DID NOT MAINTAIN RECORDS

Hello may I speak to (POC)? This is (YOUR NAME) calling on behalf of the U.S. Department of Health and Human Services. We previously spoke about the MEPS study. Thank you for providing the contact information for (NAME FROM MR3/MR10/MR12/PA2). We were able to locate (NAME FROM MR3/MR10/MR12/PA2) with the information you provided. However, they reported that they did not maintain the records for (PROVIDER(S)) in 2009. Could you please check to see if anyone else provided records for (PROVIDER(S)) in 2009?

OTHER CONTACT PROVIDED →

What is the name, title, department, and telephone number for this person?

NAME:_____
TITLE: _____
DEPARTMENT: _____
TELEPHONE:(_____)_____EXT:_____

Thank you very much for your help.

NO OTHER CONTACT PROVIDED → END CONTACT AND MARK FOR SUPERVISOR REVIEW