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MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

MEDICAL EVENT FORM

FOR

HOSPITAL PROVIDERS

FOR

REFERENCE YEAR 2009

VERSION 2.0

Revision History

Version	Author/Title	Date	Comments
1.0	Multiple RTI and SSS authors	12/23/08	
2.0	Multiple RTI and SSS authors	04/01/09	Changes from Version 1.0 marked in yellow highlighting

HOSPITAL EVENT FORM

[COMPLETE ONE FORM FOR EACH EVENT]

QUESTIONS A1 THROUGH A4: TO BE COMPLETED WITH MEDICAL RECORDS.

READ ONLY FOR FIRST EVENT FOR THIS PATIENT: (PATIENT NAME) reported that (he/she) received health care services from this facility during 2009.

1 CONFIRM PATIENT RECEIVED SERVICES (GO TO A1)

2 FACILITY KNOWS PATIENT BUT NO EVENTS RECORDED FOR 2009 (GO TO NEXT PATIENT, PAIR IS FINAL)

3 FACILITY DOES NOT KNOW PATIENT (GO TO NEXT PATIENT, REVIEW TO SEE IF DISAVOWAL IS ELIGIBLE FOR CONVERSION)

MEDICAL RECORDS

A1. The (first/next) time (PATIENT NAME) received services during calendar year 2009, were the services received:

CODE ONLY ONE

As an Inpatient;.....1 (GO TO A2a)
In a Hospital Outpatient Department;.....2 (GO TO A2c)
In a Hospital Emergency Room; or .....3 (GO TO A2c)
Somewhere else? .....4 (GO TO A2c)
(IF SOMEWHERE ELSE: Where was that?)
_____

LONG TERM CARE UNIT (SNF, etc.) (SPECIFY:) .....5 (GO TO A2a)
_____

A2a. What were the admit and discharge dates of the (event/inpatient stay)?

MO DAY YR
ADMIT: _____/_____ / _____
DISCHARGE: _____/_____ / _____
NOT YET DISCHARGED.....1

A2b. Was (PATIENT NAME) admitted from the emergency room?

YES..... 1 (COMPLETE SEPARATE EVENT FORM FOR ER EVENT)
NO..... 2

(GO TO A3)

A2c. What was the date of this visit?

MO DAY YR
_____/_____ /_____

A3. Please give me the name, specialty, and telephone number of each physician who provided services during the (TYPE OF EVENT) on (DATE(S)) **and** whose charges might not be included in the hospital bill. We want to include such doctors as radiologists, anesthesiologists, pathologists, and consulting specialists, but not residents, interns, or other doctors-in-training whose charges are included in the hospital bill.

PROBE FOR MORE THAN ONE RADIOLOGIST, ANETHESIOLOGIST, ETC OR OTHER SEPARATE BILLING MEDICAL PROFESSIONAL

RECORD NAMES ON SEPARATELY BILLING DOCTOR FORM.
IF RESPONDENT IS NOT SURE WHETHER A PARTICULAR DOCTOR'S CHARGES ARE INCLUDED IN THE HOSPITAL BILL, RECORD INFORMATION FOR THAT DOCTOR ON SEPARATELY BILLING DOCTOR FORM.

SEPARATELY BILLING DOCTORS FOR THIS EVENT.....1
NO SEPARATELY BILLING DOCTORS FOR THIS EVENT.....2

A4a. I need the diagnoses for (this stay/this visit). I would prefer the ICD-9 codes (or DSM-4 codes), if they are available.

IF CODES ARE NOT USED, RECORD DESCRIPTIONS.

[SYSTEM WILL ALLOW FOR A MAXIMUM OF 5 ICD-9 CODES TO BE COLLECTED]

CODE	DESCRIPTION
_____	_____
_____	_____
_____	_____
_____	_____

A4c. Have we covered all of this patient's events during the calendar year 2009?

YES, ALL EVENTS COVERED..... 1 (GO TO A4d)
NO, NEED TO COVER ADDITIONAL EVENTS..... 2 (GO TO A1–NEXT EVENT FORM)

A4d. IF ALL EVENTS ARE RECORDED FOR THIS PATIENT, REVIEW NUMBER OF EVENTS REPORTED BY HOUSEHOLD.	NO DIFFERENCE OR FACILITY REPORTED MORE EVENTS THAN HOUSEHOLD..... 1 (GO TO ENDING FOR MEDICAL RECORDS) FACILITY RECORDED FEWER VISITS..... 2 [DCS ONLY] PROBE: (PATIENT NAME) reported (NUMBER) events at (FACILITY) during 2009, but I have only recorded (NUMBER) visits. Do you have any information in your records that would explain this discrepancy? DON'T KNOW……1 UNACCESSIBLE ARCHIVED RECORDS….2 ACCESSIBLE ARCHIVED RECORDS…….. 3 COLLECT CONTACT INFORMATION FOR PERSON WITH RECORDS OTHER (SPECIFY):……4 _____ _____ (GO TO ENDING FOR MEDICAL RECORDS)

ENDING FOR MEDICAL RECORDS:

GO TO NEXT PATIENT. IF NO MORE PATIENTS, THANK RESPONDENT AND END. THEN ATTEMPT CONTACT WITH PATIENT ACCOUNTS OR ADMINISTRATIVE OFFICE.

QUESTIONS A5a THROUGH END: TO BE COMPLETED WITH PATIENT ACCOUNTS.

READ ONLY FOR FIRST EVENT FOR THIS PATIENT: I have information from Medical Records that (PATIENT NAME) received health care services on (DATES OF ALL VISITS AND INPATIENT STAYS REPORTED BY MEDICAL RECORDS).

I'd like to ask you about the (visit on/stay which began on) [FIRST/NEXT DATE].

1 CONFIRM PATIENT RECEIVED SERVICES (GO TO BOX 1)

2 FACILITY KNOWS PATIENT BUT NO EVENTS RECORDED FOR 2009 (GO TO NEXT PATIENT, PAIR IS FINAL)

3 FACILITY DOES NOT KNOW PATIENT (GO TO NEXT PATIENT, REVIEW TO SEE IF DISAVOWAL IS ELIGIBLE FOR CONVERSION)

BOX 1
IF EVENT IS AN OUTPATIENT VISIT OR EMERGENCY ROOM VISIT OR SOMEWHERE ELSE (A1=2, 3, or 4)), CONTINUE WITH A5a. IF EVENT IS AN INPATIENT STAY OR LONG–TERM CARE UNIT (A1=1 or 5), GO TO A8.

GLOBAL FEE

A5a. Was the visit on that date covered by a **global fee**, that is, was it included in a charge that covered services received on other dates as well?

EXPLAIN IF NECESSARY: An example would be a patient who received a series of treatments, such as chemotherapy, that was covered by a single charge.

YES..... 1
NO..... 2 (GO TO A6a)

A5b. Did the global fee for this date cover any services received while the patient was an inpatient?

YES..... 1
NO..... 2 (GO TO A5d)

A5c. What were the admit and discharge dates of that stay?

MO DAY YR
ADMIT: _____/_____/ _____
DISCHARGE: _____/_____/ _____
NOT YET DISCHARGED……..1

A5d. What were the other dates on which services covered by this global fee were provided? Please include dates before or after 2009 if they were included in the global fee.

[SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT ON NUMBER OF DATES REQUIRED]

Did (PATIENT NAME) receive the services on (DATE) in an:

Outpatient Department (TYPE=OP);
Emergency Room (TYPE=ER); or
Somewhere else (TYPE=96)?

MO	DAY	YR	TYPE	IF TYPE 96, SPECIFY:
____	____	_____	_____	_____
____	____	_____	_____	_____
____	____	_____	_____	_____
____	____	_____	_____	_____
____	____	_____	_____	_____
____	____	_____	_____	_____
____	____	_____	_____	_____
____	____	_____	_____	_____

A5e. Do you expect (PATIENT NAME) will receive any future services that will be covered by this same global fee?

YES..... 1
NO..... 2

A6a. I need to know what services were provided during (this visit/these visits). I would prefer the CPT-4 codes, if they are available.

IF CPT-4 CODES ARE NOT USED, RECORD DESCRIPTION OF SERVICES AND PROCEDURES PROVIDED.

[SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT ON CPT-4 CODES REQUIRED]

A6b. ASK FOR EACH CPT-4 CODE OR DESCRIPTION: What was the **full established charge** for this service, before any adjustments or discounts?

EXPLAIN IF NECESSARY: The **full established charge** is the charge maintained in the hospital's master fee schedule for billing insurance carriers and Medicare or Medicaid. 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 for purposes of budgeting or cost analysis. This is sometimes called a "**charge equivalent**." Could you give me the charge equivalent(s) for (this/these) procedure(s)?

VERIFY: (Is this/Are these) the full established charge(s) or "list price" for (this/these) service(s)? IF NOT, RECORD FULL ESTABLISHED CHARGES.

	CODE	DESCRIPTION	Full established charge at time of visit or charge equivalent
a.	_____	_____	$_____.____
b.	_____	_____	$_____.____
c.	_____	_____	$_____.____
d.	_____	_____	$_____.____
e.	_____	_____	$_____.____
f.	_____	_____	$_____.____
g.	_____	_____	$_____.____
h.	_____	_____	$_____.____
i.	_____	_____	$_____.____
j.	_____	_____	$_____.____
k.	_____	_____	$_____.____

TOTAL CHARGES **$_____.___**

C2. I show the total charge as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct? IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

C3. Was the facility reimbursed for (this visit/these visits) on a fee-for-service basis or capitated basis?

EXPLAIN IF NECESSARY:
Fee-for-service means that the facility was reimbursed on the basis of the services provided.

Capitated basis means that the patient was enrolled in a prepaid managed care plan where reimbursement is not tied to specific visits.

IF IN DOUBT, CODE FEE-FOR-SERVICE.

FEE-FOR-SERVICE BASIS 1
CAPITATED BASIS..... 2 (GO TO C7a)

C4. From which of the following sources has the facility received payment for (this visit/these visits) and how much was paid by each source? Please include all payments that have taken place between (VISIT DATE) and now for this visit.
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 "SOMETHING ELSE" 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 C3 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?)
_____ $_____.____

C5. I show the total payment as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct?
IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS **$_____.__**

BOX 2
DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?

YES, AND ALL PAID BY PATIENT OR PATIENT'S FAMILY…….. 1 (GO TO BOX 3)

YES, OTHER PAYERS……..2 (GO TO C5a)

NO…….. ….3 (GO TO C6)

IF, AFTER VERIFICATION, PAYMENTS DO NOT EQUAL CHARGES COMPLETE C6 AND GO TO BOX 3

.

C5a 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 C5]. 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 C4.

YES, FINAL PAYMENTS RECORDED IN C4 AND C5……..1 (GO TO BOX 3)
NO……2 (GO BACK TO C4)

.

C6. It appears that the total payments were (less than/more than) the total charges. What is the reason for that difference? Please include all adjustment activity that has taken place between (VISIT DATE) and now for this visit.

CODE 1 (YES) FOR ALL REASONS MENTIONED.

PAYMENTSLESS THAN CHARGES:	YES	NO
Adjustment or discount		
a. Medicare limit or adjustment;.....	1	2
b. Medicaid limit or adjustment;.....	1	2
c. Contractual arrangement with insurer or managed care organization;.....	1	2
d. Courtesy discount;.....	1	2
e. Insurance write-off;.....	1	2
f. Worker's Comp limit or adjustment;.....	1	2
g. Eligible veteran; or.....	1	2
h. Something else?……..	1	2

(IF SOMETHING ELSE: What was that?)

_____

Expecting additional payment		
i. Patient or Patient's Family;.....	1	2
j. Medicare;.....	1	2
k. Medicaid;.....	1	2
l. Private Insurance;.....	1	2
m. VA/Champva;.....	1	2
n. Tricare;.....	1	2
o. Worker's Comp; or	1	2
p. Something else?……..	1	2

(IF SOMETHING ELSE: What was that?)

_____

q. **Charity care or sliding scale;**.....	1	2
r. **Bad debt;**.....	1	2
PAYMENTS MORE THAN CHARGES:		
s. Medicare adjustment;.....	1	2
t. Medicaid adjustment;.....	1	2
u. Private insurance adjustment; or.....	1	2
v. Something else?……..	1	2

(IF SOMETHING ELSE: What was that?)

_____

(GO TO BOX 3)

CAPITATED BASIS

C7a. What kind of insurance plan covered the patient for (this visit/these visits)? 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.

	YES	NO
a. Medicare;.....	1	2
b. Medicaid;.....	1	2
c. Private Insurance;.....	1	2
d. VA/Champva;.....	1	2
e. Tricare;.....	1	2
f. Worker's Comp; or.....	1	2
g. Something else?.....	1	2

(IF SOMETHING ELSE: What was that?)
_____

C7b. Was there a co-payment for (this visit/these visits)?

YES..... 1
NO..... 2(GO TO C7e)

C7c. How much was the co-payment?

$_____._____

C7d. 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?

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

	YES	NO
a. Patient or Patient's Family;.....	1	2
b. Medicare;.....	1	2
c. Medicaid;.....	1	2
d. Private Insurance; or.....	1	2
e. Something else? ……	1	2

(IF SOMETHING ELSE: What was that?)
_____

C7e. Do your records show any other payments for (this visit/these visits)?

YES..... 1
NO..... 2(GO TO BOX 3)

C7f. From which of the following other sources has the facility received payment for (this visit/these visits) and how much was paid by each source? Please include all payments that have taken place between (VISIT DATE) and now for this visit.

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; or.....	$_____._____
h. Something else?	
(IF SOMETHING ELSE: What was that?)	
_____	$_____._____

BOX 3

GLOBAL FEE SITUATION (A5a=YES).....1	**(GO TO A11)**
RECORDED 5 OR FEWER EVENTS 2	**(GO TO A11)**
RECORDED 6 OR MORE EVENTS 3	**(GO TO A7a)**

REPEATING IDENTICAL VISITS

A7a. Were there any other visits for this patient during 2009 for which the services and charges were identical to the services and charges for the visit on (DATE OF THIS EVENT)? EXPLAIN, IF NECESSARY: We are referring here to **repeating identical visits**. These usually occur when the patient has a condition that requires very frequent visits, such as once- or twice-a-week physical therapy.	YES.. 1 NO... 2 (GO TO A11)
A7b. During 2009 how many other visits were there for which the services and charges were identical to those on (DATE OF THIS EVENT)?	# OF VISITS_____________
A7c. Please tell me the dates of those other visits. [SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT ON NUMBER OF DATES REQUIRED]	MO/DAY/YR MO/DAY/YR MO/DAY/YR ___/___ 20___ ___/___ 20 ___ ___/___ 20 ___ ___/___ 20___ ___/___ 20 ___ ___/___ 20 ___ ___/___ 20___ ___/___ 20 ___ ___/___ 20 ___ ___/___ 20___ ___/___ 20 ___ ___/___ 20 ___ ___/___ 20___ ___/___ 20 ___ ___/___ 20 ___ ___/___ 20___ ___/___ 20 ___ ___/___ 20 ___ ___/___ 20___ ___/___ 20 ___ ___/___ 20 ___ ___/___ 20___ ___/___ 20 ___ ___/___ 20 ___ ___/___ 20___ ___/___ 20 ___ ___/___ 20 ___ ___/___ 20___ ___/___ 20 ___ ___/___ 20 ___ (GO TO A11)

PATIENT ACCOUNTS QUESTIONS FOR INPATIENT.

A8. According to Medical Records, (PATIENT NAME) was an inpatient during the period from [ADMIT DATE] to [DISCHARGE DATE]. What was the DRG for this stay?

DRG IS A CODE USED TO CLASSIFY INPATIENT STAYS AND IT IS USUALLY ONE TO THREE DIGITS LONG.

[SYSTEM WILL COLLECT A RANGE OF 1 TO 989 FOR THE DRG]

DRG:_____ (GO TO C2a)

DRG NOT RECORDED..... 1 (GO TO A9)

A9. Did the patient have any surgical procedures during this stay?

YES..... 1

NO..... 2 (GO TO C2a)

A10a. What surgical procedures were performed during this stay? Please give me the procedure codes, that is the CPT-4 codes, if they are available.

IF CPT-4 CODES ARE NOT USED, RECORD DESCRIPTION OF SERVICES AND PROCEDURES PROVIDED.

[SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT ON CPT-4 CODES REQUIRED]

CODE	DESCRIPTION
_____	_____
_____	_____
_____	_____
_____	_____

C2a.

What was the **full established charge** for this inpatient stay, before any adjustments or discounts?

IF PATIENT WAS ADMITTED FROM ER (A2b=YES) READ: Please do not include any emergency room charges.

EXPLAIN IF NECESSARY: The **full established charge** is the charge maintained in the hospital's master fee schedule for billing insurance carriers and Medicare or Medicaid. 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 for purposes of budgeting or cost analysis. This is sometimes called a "**charge equivalent**." Could you give me the charge equivalent for this inpatient stay?

VERIFY: Is this the total full established charge or "list price" for (this/these) service(s)? IF NOT, RECORD FULL ESTABLISHED CHARGE.

FULL ESTABLISHED CHARGE OR CHARGE EQUIVALENT:

$_____ . _____

IF HS EVENT (IF A1=1 OR 5):
EMERGENCY ROOM CHARGE INCLUDED..... 1
EMERGENCY ROOM CHARGE NOT INCLUDED OR NOT APPLICABLE..... 2

IF IC EVENT (IF A1=5):
ANCILLARY CHARGES INCLUDED..... 1
ANCILLARY CHARGES NOT INCLUDED OR NOT APPLICABLE..... 2

C3. Was the facility reimbursed for this inpatient stay on a fee-for-service basis or capitated basis?

EXPLAIN IF NECESSARY:
Fee-for-service means that the facility was reimbursed on the basis of the services provided.

Capitated basis means that the patient was enrolled in a prepaid managed care plan where reimbursement is not tied to specific visits.

IF IN DOUBT, CODE FEE-FOR-SERVICE.

FEE-FOR-SERVICE BASIS 1
CAPITATED BASIS..... 2 (GO TO C7a)

C4. From which of the following 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?

[SYSTEM WILL SET UP "SOMETHING ELSE" 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 C3 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?)
_____ $_____.____

C5. I show the total payment as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct? IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS **$_____.__**

BOX 5
DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?

YES, AND ALL PAID BY PATIENT OR PATIENT'S FAMILY…….. 1 (GO TO A11)

YES, OTHER PAYERS……..2 (GO TO C5a)

NO…….. ….3 (GO TO C6)

IF, AFTER VERIFICATION, PAYMENTS DO NOT EQUAL CHARGES COMPLETE C6 AND GO TO A11

C5a I recorded that the payment(s) you received equal the charge. 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 C5]. 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 C4.

YES, FINAL PAYMENTS RECORDED IN C4 AND C5……..1 (GO TO A11)
NO……2 (GO BACK TO C4)

C6. It appears that the total payments were (less than/more than) the total charges. What is the reason for that difference? Please include all adjustment activity that has taken place between (ADMIT DATE) and now for this stay.
CODE 1 (YES) FOR ALL REASONS MENTIONED.

PAYMENTS LESS THAN CHARGES:	YES	NO
Adjustment or discount		
a. Medicare limit or adjustment;.....	1	2
b. Medicaid limit or adjustment;.....	1	2
c. Contractual arrangement with insurer or managed care organization;.....	1	2
d. Courtesy discount;.....	1	2
e. Insurance write-off;.....	1	2
f. Worker's Comp limit or adjustment;.....	1	2
g. Eligible veteran; or.....	1	2
h. Something else?……	1	2
(IF SOMETHING ELSE: What was that?) _____		
Expecting additional payment		
i. Patient or Patient's Family;.....	1	2
j. Medicare;.....	1	2
k. Medicaid;.....	1	2
l. Private Insurance;.....	1	2
m. VA/Champva;.....	1	2
n. Tricare;.....	1	2
o. Worker's Comp; or	1	2
p. Something else?.....	1	2
(IF SOMETHING ELSE: What was that?) _____		
q. **Charity care or sliding scale;**.....	1	2
r. **Bad debt;**.....	1	2
PAYMENTS MORE THAN CHARGES:		
s. Medicare adjustment;.....	1	2
t. Medicaid adjustment;.....	1	2
u. Private insurance adjustment; or.....	1	2
v. Something else? ……	1	2
(IF SOMETHING ELSE: What was that?) _____		

(GO TO A11)

CAPITATED BASIS

C7a. 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

.

	YES	NO
a. Medicare;.....	1	2
b. Medicaid;.....	1	2
c. Private Insurance;.....	1	2
d. VA/Champva;.....	1	2
e. Tricare;.....	1	2
f. Worker's Comp; or.....	1	2
g. Something else?	1	2

(IF SOMETHING ELSE: What was that?)

_____

C7b. Was there a co-payment for any part of this stay?

YES..... 1
NO..... 2(GO TO C7e)

C7c. How much was the co-payment?

$_____.__

C7d. 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?

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

	YES	NO
a. Patient or Patient's Family;.....	1	2
b. Medicare;.....	1	2
c. Medicaid;.....	1	2
d. Private Insurance; or.....	1	2
e. Something else?……..	1	2

(IF SOMETHING ELSE: What was that?)

_____

C7e. Do your records show any other payments for this stay?

YES..... 1
NO..... 2(GO TO A11)

C7f. 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; or..... $_____.____
h. Something else?
(IF SOMETHING ELSE: What was that?)
_____ $_____.____

A11. ARE THERE ANY ADDITIONAL EVENTS FOR THIS PATIENT TO BE ACCOUNTED FOR?

YES..... 1 (GO TO PATIENT ACCOUNTS SECTION (A5a) OF NEXT EVENT FORM.)

NO..... 2 (GO TO NEXT PATIENT. IF NO MORE PATIENTS, THANK RESPONDENT AND END.)