Form Approved
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MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

MEDICAL EVENT FORM

FOR

INSTITUTIONAL PROVIDERS
(NON-HOSPITAL FACILITIES)

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	Originally delivered 3/4/09, Redelivered 04/01/09	Changes from Version 1.0 marked in yellow highlighting

INSTITUTIONAL EVENT FORM

[COMPLETE ONE FORM FOR EACH STAY]

QUESTIONS 1 THROUGH 3: TO BE COMPLETED WITH MEDICAL RECORDS.

READ ONLY FOR FIRST STAY FOR THIS PATIENT: Someone in (PATIENT)'s family reported that (he/she) was a patient in this facility during 2009.

1 CONFIRM PATIENT RECEIVED SERVICES (GO TO Q1)

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

1. What were the admit and discharge dates of the (first/next) stay?

MO DAY YR

ADMIT: _____/_____/_____

DISCHARGE: _____/_____/_____

NOT YET DISCHARGED.....1

2a. I need the diagnoses for this stay. I would prefer the ICD-9 codes (or DSM-IV 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

_____ _____

_____ _____

_____ _____

_____ _____

3. Please give me the name, specialty, and telephone number 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.

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

DOES NOT HAVE THIS INFORMATION……0 COLLECT CONTACT INFORMATION FOR PERSON WITH RECORDS

SEPARATELY BILLING DOCTORS FOR THIS EVENT……..1

NO SEPARATELY BILLING DOCTORS FOR THIS STAY……..2

4a. Have we covered all of this patient's stays during the calendar year 2009?

YES, ALL STAYS COVERED..... 1 (GO TO Q4b)

NO, NEED TO COVER ADDITIONAL STAYS..... 2 (GO TO Q1-NEXT EVENT FORM)

4b. IF ALL STAYS ARE RECORDED FOR THIS PATIENT, REVIEW NUMBER OF STAYS REPORTED BY HOUSEHOLD.

NO DIFFERENCE OR FACILITY REPORTED MORE STAYS THAN HOUSEHOLD..... 1 (GO TO ENDING FOR MEDICAL RECORDS)

FACILITY RECORDED FEWER STAYS..... 2

[DCS ONLY] PROBE: (PATIENT NAME) reported (NUMBER) stays at (FACILITY) during 2009, but I have only recorded (NUMBER) stays. 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.

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QUESTIONS 5 THROUGH END: TO BE COMPLETED WITH PATIENT ACCOUNTS.

According to Medical Records, (PATIENT NAME) was a patient in your facility during the period from (ADMIT DATE) to (DISCHARGE DATE/END OF 2009).

1 CONFIRM PATIENT RECEIVED SERVICES (GO TO Q5)

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)

5. Was the facility reimbursed for this stay on a fee-for-service basis or a 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, such as an HMO, and reimbursement to the facility was not based on the services provided.

   IF IN DOUBT, CODE FEE-FOR-SERVICE.

FEE-FOR-SERVICE BASIS 1
CAPITATED BASIS..... 2 (GO TO Q21a)

BASIC CHARGES

6. 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 2009)?

   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?

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

FULL ESTABLISHED CHARGE OR CHARGE EQUIVALENT:

$_____ . _____ (GO TO Q7)

CAN'T GIVE TOTAL CHARGE.....991 (GO TO Q10)
NO CHARGE.....992 (GO TO Q6a)

6a. Why is there no charge for room, board, and basic care for this stay?

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

(GO TO Q14)

7. 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?) _____	$_____.____
TOTAL PAYMENTS	**$_____.__**

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

BOX 1

DO TOTAL PAYMENTS EQUAL TOTAL CHARGE?

YES, AND ALL PAID BY PATIENT OR PATIENT'S FAMILY…… 1 (GO TO Q14)

YES, OTHER PAYERS…… 2 (GO TO Q8a)

NO…….. …….. 3 (GO TO Q9)

IF, AFTER VERIFICATION, PAYMENTS DO NOT EQUAL CHARGE COMPLETE Q9 AND GO TO Q14

8a. 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 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)

9. It appears that the total payments were (less than/more than) the total charge. What is the reason for this 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 CHARGE:	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 CHARGE:		
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 Q14)

10. Can you tell me what the facility's full established daily rate for room and board and basic care was during this stay?

$_____ . _____ (GO TO Q11)

RATE CHANGED DURING STAY……991 (GO TO Q12)
NO CHARGE.....992 (GO TO Q10a)

10a. Why was there no charge for room, board, and basic care for this stay?

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

(GO TO Q14)

11. For how many days was the patient charged during this stay? (Please give only the days during 2009.)

_____ # DAYS

IF RESPONDENT CAN'T PROVIDE TOTAL DAYS, GO TO Q12.
OTHERWISE, CONTINUE.

11a. 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; or	$_____.____
h. Something else? (IF SOMETHING ELSE: What was that?) _____	$_____.____
TOTAL PAYMENTS	**$**_____**.**__

11b. I show the total payment as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct? IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

(GO TO Q14)

12. Perhaps it would be easier if you gave me the information billing period by billing period.

BILLING PERIOD #1

BILLING PERIOD # ___ BILLING START DATE: _____/_____/_____ MO DY YR BILLING END DATE: _____/_____/_____ MO DY YR # DAYS IN BILLING PERIOD: _____		12-1. Between (BP DATES), how many days was the patient charged for room and board and basic care? _____ # BILLED DAYS	IF # BILLED DAYS IS LESS THAN # DAYS IN BP, Please explain why the number of days the patient was charged for room and board and basic care is less than the number of days in the billing period:	
12-2. Between (BP DATES), what was the private pay rate for room and board and basic care (PERSON) received? If the rate changed, please give me the first one. $_____.____	12-3. How many days would that rate have applied during this billing period? _____ # DAYS (GO TO Q12-6)			12-6. LOOK AT Q12-1. ARE ALL BILLED DAYS ACCOUNTED FOR? Yes.....1 [RATE WILL BE RECORDED IN Q12-8] No.....2 (GO TO Q12-2A)
12-2A. Between (BP DATES), what other private pay rate applied to the basic care that (PERSON) received? $_____.____	12-3A. On what date did this rate begin? ____/____/____ MO DY YR DK.....-8	12-4A. During this billing period, how many days would that rate have applied? # DAYS: _____	12-5A. Why did the rate change? CODE ONLY ONE. LEVEL OF CARE…1 PATIENT DISCHARGED: TO HOSPITAL.....2 TO COMMUNITY. 3 TO OTHER FACILITY.....4 RATE INCREASE...5 ROOM CHANGE….6 OTHER, SPECIFY..7 _____	12-6A. LOOK AT Q12-1. ARE ALL BILLED DAYS ACCOUNTED FOR? Yes.....1 (GO TO Q12-7) No.....2 (GO TO Q12-2B)
12-2B. Between (BP DATES), what other private pay rate applied to the basic care that (PERSON) received? $_____.____	12-3B. On what date did this rate begin? ____/____/____ MO DY YR DK.....-8	12-4B. During this billing period, how many days would that rate have applied? # DAYS: _____	12-5B. Why did the rate change? CODE ONLY ONE. LEVEL OF CARE…1 PATIENT DISCHARGED: TO HOSPITAL.....2 TO COMMUNITY. 3 TO OTHER FACILITY.....4 RATE INCREASE...5 ROOM CHANGE….6 OTHER, SPECIFY..7 _____	12-6B. LOOK AT Q12-1. ARE ALL BILLED DAYS ACCOUNTED FOR? Yes.....1 (GO TO Q12-7) No.....2 [SYSTEM WILL REGENERATE 12-2B AS NECESSARY]

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

YES..... 1 [RATE WILL BE RECORDED IN Q12-8]
NO..... 2 (GO TO Q12-8)

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

13. 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; or $_____.____

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

13a. I show the total payment for this billing period as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct?
IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS $_____.____

INDICATE WHETHER INFORMATION NEEDS TO BE COLLECTED FOR ANOTHER BILLING PERIOD

€ NEXT BILLING PERIOD [SYSTEM WILL REGENERATE Q12, Q13, AND Q13A FOR THE NEXT BILLING PERIOD]
€ NO MORE BILLING PERIODS (GO TO Q14)

ANCILLARY CHARGES

14. 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?)

YES..... 1
NO..... 2 (GO TO Q22)

15. 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.

TOTAL CHARGES: $_____.___ (GO TO Q16)

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).

l__l CHECK HERE IF RESPONDENT CAN'T SEPARATE HEALTH AND NON-HEALTH RELATED ANCILLARY CHARGES (GO TO Q16).

l__l CHECK HERE IF RESPONDENT CAN'T GIVE TOTAL ANCILLARY CHARGES (GO TO Q19).

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

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

17. 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 Q22)

YES, OTHER PAYERS…… 2 (GO TO Q17a)

NO…….. …… 3 (GO TO Q18)

IF, AFTER VERIFICATION, PAYMENTS DO NOT EQUAL CHARGES COMPLETE Q18 AND GO TO Q22

17a. 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 (GO TO Q22)
NO……2 (GO BACK TO Q16)

18. It appears that the total payments were (less than/more than) the total charges. What is the reason for this 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? …… (IF SOMETHING ELSE: What was that?) _____	1	2
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? …… (IF SOMETHING ELSE: What was that?) _____	1	2
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? …… (IF SOMETHING ELSE: What was that?) _____	1	2

(GO TO Q22)

19. Perhaps it would be easier if you gave me the information billing period by billing period.

	BP1	BP2	BP3	BP4	BP5	LAST BP
a. First, what was the start date of the first billing period in which (PATIENT) was a patient? ENTER MONTH ONLY IF BILLING PERIOD IS MONTHLY.	_____ (MONTH) (GO TO Q19c) or ____/____/___ (START DATE)	_____ (MONTH) (GO TO Q19c) or ____/____/___ (START DATE)	_____ (MONTH) (GO TO Q19c) or ____/____/___ (START DATE)	_____ (MONTH) (GO TO Q19c) or ____/____/___ (START DATE)	_____ (MONTH) (GO TO Q19c) or ____/____/___ (START DATE)	_____ (MONTH) (GO TO Q19c) or ____/____/___ (START DATE)
b. And what was the end date?	____/____/___ (END DATE)	____/____/___ (END DATE)	____/____/___ (END DATE)	____/____/___ (END DATE)	____/____/___ (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.	$_____.____	$_____.____	$_____.____	$_____.____	$_____.____	$_____.____
	(GO TO NEXT BP)	(GO TO NEXT BP)	(GO TO NEXT BP)	(GO TO NEXT BP)	(GO TO NEXT BP)	

20. From which of the following sources did the facility receive payments for ancillary charges 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						
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?) _____	$_____.____	$_____.____	$_____.____	$_____.____	$_____.____	$_____.___
	(GO TO NEXT BP)	(GO TO NEXT BP)	(GO TO NEXT BP)	(GO TO NEXT BP)	(GO TO NEXT BP)	(GO TO Q22)

20a. [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.

CAPITATED BASIS

21a. 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?)
_____

21b. What was the monthly payment from that plan?

$_____.__

21c. Was there a co-payment for any part of this stay?

YES..... 1
NO..... 2 (GO TO Q21g)

21d. How much was the co-payment?
[DCS ONLY] PROBE TO DETERMINE IF FOR DAY, WEEK, ETC.

$_____.__

per
DAY..... 1
WEEK..... 2
MONTH..... 3
OTHER..... 4
SPECIFY: _____
DON'T KNOW..... 8

21e. For how many (days/weeks/months/other) was the co-payment paid?

_____#

DON'T KNOW..... 98

21f. 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?)
_____

21g. Do your records show any other payments for this stay?

YES..... 1
NO..... 2(GO TO Q22)

21h. 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?)	
_____	$_____.____

22. ARE THERE ANY ADDITIONAL STAYS FOR THIS PATIENT TO BE ACCOUNTED FOR?

YES..... 1 (GO TO PATIENT ACCOUNTS SECTION (Q5) OF NEXT EVENT FORM.)
NO..... 2 (GO TO NEXT PATIENT. IF NO MORE PATIENTS, THANK RESPONDENT AND END.)