Instructions (Fax Version)

Medical Provider Component

MEDICAL EXPENDITURE PANEL SURVEY

HOME CARE

[FILL PROVIDER ID]

[FILL PROVIDER NAME:]

Instructions

Thank you for taking the time to provide this medical billing information. We realize your time is valuable and limited. If you would like to contact us directly, please call [FILL APPROPRIATE 800 NUMBER].

The client(s) listed below have given us written authorization to contact you and request information from your records. Copies of the signed authorization forms are attached.

Please complete the following steps to provide us with the records we need.

Step 1: Please Locate Medical Billing Records for Each Client in Your Records: For each client included in the Confidential Client Checklist, please locate the following information on all services each client received between January 1, 2009 and December 31, 2009:

- Date(s) of service
- Services provided
- Type of personnel who delivered services
- Diagnoses/conditions
- Payments and who made them (private insurance, Medicare, Medicaid, out-of-pocket, etc.)
- Charges for each service provided and total charges

Step 2: Please Record Outcome on the Confidential Client Checklist: Please indicate whether you were able to locate the 2009 client records, if you were able to locate the client but there were no 2009 records, or if the individual is not a client, by checking the appropriate box next to the client in the Confidential Client Checklist.

Step 3: Please Provide Information via Fax or Mail: Please assemble the information for all clients in the Confidential Client Check List and fax or mail it to us, using the Fax or Mail Return Form. Please include the completed Confidential Client List, with the appropriate box checked for each client, in the package. If we do not hear from you, a data collection specialist will contact you to arrange for the collection of these data. If you would prefer to provide the medical billing information over the telephone we can arrange for the collection of these data at your convenience. Please call [FILL APPROPRIATE 800 NUMBER].

Confidential Client Check List

Medical Provider Component

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[FILL PROVIDER ID]

PROVIDER NAME:

Confidential Client Check List

Please use the check list below as a way to record the outcome of locating each client record in your files, and include it when faxing or mailing your materials. If you choose to provide the medical billing information over the telephone, you may use this list as a reference tool for recording the outcome of locating each client record in your files.

REMINDER:
IF RETURNING RECORDS BY FAX OR MAIL, PLEASE INCLUDE THIS CHECKLIST FORM.

If faxing material, please fax to:
[FILL APPROPRIATE RTI-SSS NUMBER: 1-800-XXX-XXXX]

If mailing material, please send to:
MEPS-Medical Provider Component Director
One North Commerce Center
5265 Capital Boulevard
Raleigh, NC 27616

			CHECK ONE FOR EACH CLIENT:		
Client Name	**Date of Birth**	**Gender**	**2009 Client Records Located**	**Found Client, No 2009 Records**	**Is Not A Client**
1. [FILL NAME]	[FILL DOB]	[FILL M or F]	❑	❑	❑
2. [FILL NAME]	[FILL DOB]	[FILL M or F]	❑	❑	❑
3. [FILL NAME]	[FILL DOB]	[FILL M or F]	❑	❑	❑
4. [FILL NAME]	[FILL DOB]	[FILL M or F]	❑	❑	❑
5. [FILL NAME]	[FILL DOB]	[FILL M or F]	❑	❑	❑
6. [FILL NAME]	[FILL DOB]	[FILL M or F]	❑	❑	❑
7. [FILL NAME]	[FILL DOB]	[FILL M or F]	❑	❑	❑
8. [FILL NAME]	[FILL DOB]	[FILL M or F]	❑	❑	❑

Confidential Client Check List

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Client Name	Date of Birth	Gender	CHECK ONE FOR EACH CLIENT: 2009 Client Records Located	Found Client, No 2009 Records	Is Not A Client
9. [FILL NAME]	[FILL DOB]	[FILL M or F]	❑	❑	❑
10. [FILL NAME]	[FILL DOB]	[FILL M or F]	❑	❑	❑
11. [FILL NAME]	[FILL DOB]	[FILL M or F]	❑	❑	❑
12. [FILL NAME]	[FILL DOB]	[FILL M or F]	❑	❑	❑
13. [FILL NAME]	[FILL DOB]	[FILL M or F]	❑	❑	❑
14. [FILL NAME]	[FILL DOB]	[FILL M or F]	❑	❑	❑
15. [FILL NAME]	[FILL DOB]	[FILL M or F]	❑	❑	❑
16. [FILL NAME]	[FILL DOB]	[FILL M or F]	❑	❑	❑
17. [FILL NAME]	[FILL DOB]	[FILL M or F]	❑	❑	❑
18. [FILL NAME]	[FILL DOB]	[FILL M or F]	❑	❑	❑