

Form Approved  
OMB No. 0935-0118  
Exp. Date 01/31/2013

**MEDICAL EXPENDITURE PANEL SURVEY**  
**MEDICAL PROVIDER COMPONENT**  
**DATA FORM**  
**FOR**  
**PHARMACIES**  
**FOR**  
**REFERENCE YEAR 2010**  
**VERSION 1.0**

**Revision History**

<b>Version</b>	<b>Author/Title</b>	<b>Date</b>	<b>Comments</b>
1.0	Multiple RTI and SSS authors	3/25/10	Changes from final 2009 version made via track changes

1. VERIFY ALL PATIENT(S)

First, I'd like to review the patient(s) in our study who reported receiving care from your practice or facility during 2010. I'm going to read their names to you, and for each one please confirm whether the patient received health care services from you during the calendar year 2010.

For each of the patient(s) you confirm as receiving care during the calendar year 2010, I'll need to ask about services you provided and charges for those services. I will ask about each confirmed patient individually.

READ EACH PATIENT NAME FROM THE LIST. IF THE PERSON ON THE PHONE SAYS "NO", ASK: Did the patient receive services in some year other than 2010, or do you have no records at all?

FOR EACH LISTED PATIENT, CHOOSE A RESPONSE FROM THE DROP-DOWN LIST IN THE PATIENT CONFIRMATION COLUMN BELOW.

ONCE YOU CONFIRM A PATIENT FOR 2010, CLICK ON THE NAME OF THAT PATIENT AND COMPLETE THE EVENT FORM(S) FOR THAT PATIENT.

1. PATIENT DISAVOWAL

Finally, I need to review with you the patient(s) in the list who you indicated did not receive care during the calendar year 2010.

2. CLOSE OUT THE CALL

Thank you for your time.

Do you have any (more) medical events for (PATIENT NAME) for 2010?

**OMB SECTION**

DCS: READ THIS ALOUD ONLY IF REQUESTED BY RESPONDENT.

PRESS NEXT TO CONTINUE IN THIS EVENT FORM

PRESS BREAKOFF TO DISCONTINUE

(Public reporting burden for this collection of information is estimated to average 5 minutes per response, the estimated time required to complete the survey. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-0118) AHRQ, 540 Gaither Road, Room # 5036, Rockville, MD 20850.)  
OMB No. 0935-0118; Exp. Date 1/31/2013

**Q1.** Date Filled:  
MONTH:  
DAY:  
YEAR:

DK/REF/RETRIEVABLE -- CONTINUE TO Q2

**Q2.** Prescription information will be identified using:  
NOTE: TRY TO OBTAIN NDC. USE DRUG NAME  
ONLY IF NDC NOT AVAILABLE.

[IF R\_RXIDTYPE = 1 (NDC), GO TO Q2a;  
IF R\_RXIDTYPE = 2 (Drug Name, Strength/Unit, & Dosage Form), GO TO Q2b]

DO NOT ALLOW DK/REF/RETRIEVABLE

**Q2a.** NDC  
NOTE THAT NDC FORMAT IS COMPOSED OF DIGITS AND DASHES  
IF DRUG IS A COMPOUND ENTER NDC CODE OR 99999-9999-96

(GO TO Q3a/b)

**Q2b.** Drug Name:

DK/REF/RETRIEVABLE -- CONTINUE TO Q2c/d

**Q2c.** Strength:

**Q2d.** Unit:  Other, Specify:

NOTE: WHERE NECESSARY, YOU MAY ENTER A SECOND STRENGTH AND UNIT, FOR EXAMPLE TO DESCRIBE A SOLUTION OR CONCENTRATION (e.g., 7 mg/5 ml). OTHERWISE SKIP TO **2e**, DOSAGE FORM.

DK/REF/RETRIEVABLE -- CONTINUE TO Q2e

**Q2c2.** Strength 2:

**Q2d2.** Unit 2:  Other, Specify:

**Q2e.** Dosage Form:

Other, Specify:

CONTINUE TO Q3a/b.

**Q3a.** Quantity:

**NOTE 1:** QUANTITY SHOULD REFLECT THE CONTENTS OF A CONTAINER, NOT THE NUMBER OF CONTAINERS.

EXCEPTION: IF NDC PROVIDED, THEN NUMBER OF EPIPENS CAN BE RECORDED FOR QUANTITY, AS OPPOSED TO QUANTITY OF EIPEN CONTENTS.

**NOTE 2:** FOR A DEVICE, ACCEPT A QUANTITY OF 1 OR 2.

**NOTE 3:** FOR PILLS, ACCEPT A QUANTITY OF 1 OR 2.

EXCEPTION: IF IT APPEARS THE QUANTITY IS FOR ONE OR TWO DOSEPAKS CONTAINING MULTIPLE PILLS, THEN RECORD THE QUANTITY OF TABLETS, CAPSULES, ETC., THAT EACH DOSEPAK CONTAINS.

**NOTE 4:** FOR OINTMENTS, CREAMS, DROPS, LIQUID, FILLED SYRINGES (EXCEPT EPIPENS) AND OTHER DOSAGE FORMS NEEDING A QUANTITY UNIT, ASK FOR THE QUANTITY OF THE CONTENTS.

ALLOW DK/RF/RETRIEVABLE

POST-LOGIC FOR Q3a: AFTER RECORDING Q3a, IF R\_RXIDTYPE=1 AND NDC NE DK/RF/RET, SKIP USER TO R\_DAYSSUP

DK/REF/RETRIEVABLE -- CONTINUE TO Q3b

**Q3b.** Quantity Unit:  OTHER, PLEASE SPECIFY:

DK/REF/RETRIEVABLE -- CONTINUE TO Q4

**Q4.** How many days were supplied?

NOTE: IF PRESCRIPTION WAS TO BE USED "AS NEEDED" ENTER 999

DK/REF/RETRIEVABLE -- CONTINUE TO Q5

**Q5.** Patient Payment: \$\_\_\_\_.\_\_\_\_

**Q5a.** Were there any 3rd party payers?

[IF YES, GO TO Q6. IF NO, GO TO END.]

**Q6.** Type of 3<sup>rd</sup> Party Payer

SOURCE:

OTHER SPECIFY

**Q7.** 3<sup>rd</sup> Party Payment:

\$\_\_\_\_\_

NOTE: IF PATIENT PAYMENT WAS \$1 OR LESS, EXPECT THE 3<sup>rd</sup> PARTY PAYER TO BE A PUBLIC PROGRAM, E.G., MEDICAID OR OTHER STATE/LOCAL GOVT, ETC.