

ATTACHMENT 92

MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

EVENT FORM

FOR

**INSTITUTIONAL PROVIDERS
(NON-HOSPITAL FACILITIES)**

FOR

REFERENCE YEAR 2014

SECTION 1 – OMB HYPERLINK ON FIRST SCREEN

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 3 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 XX/XX/XXXX

SECTION 2 – MEDICAL RECORDS – EVENT DATE

[PAGE 1 – MEDICAL RECORDS – EVENT DATE (1 of 1)]

A1. What were the admit and discharge dates of the (first/next) stay?

ADMIT:	MONTH	DAY	YEAR
DISCHARGE:	MONTH	DAY	YEAR
NOT YET DISCHARGED.....1			

Not2014

YOU ENTERED DATES FOR A SINGLE STAY THAT INCLUDED ALL OF 2014.

IF THIS WAS AN ERROR PRESS "PREVIOUS" TO CORRECT YOUR DATE ENTRIES.

IF THIS IS CORRECT PRESS "NEXT."

SECTION 3 – MEDICAL RECORDS – DIAGNOSES

[PAGE 2 – MEDICAL RECORDS - DIAGNOSES (1 of 1)]

A3. I need the diagnoses for this stay. I would prefer the ICD-9 codes (or DSM-IV codes), if they are available.	CODE	DESCRIPTION
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IF CODES ARE NOT USED, RECORD DESCRIPTIONS. CHECK HERE IF THIS IS AN ICD-10 CODE

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

SECTION 4 – MEDICAL RECORDS – SBD

[PAGE 3 – MEDICAL RECORDS - SBD (1 of 1)]

A2. I need to record the name and specialty 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.

- SEPARATELY BILLING DOCTORS FOR THIS EVENT.....1
- NO** SEPARATELY BILLING DOCTORS FOR THIS STAY.....2
- DO NOT HAVE THIS INFORMATION.....3

PROBE FOR MORE THAN ONE RADIOLOGIST, ANESTHESIOLOGIST, ETC OR OTHER SEPARATELY BILLING MEDICAL PROFESSIONAL.

IF RESPONDENT IS UNSURE WHETHER A PARTICULAR DOCTOR'S CHARGES ARE INCLUDED IN THE INSTITUTION BILL, RECORD YES HERE.

EF1 Can you please provide the full name of the (first/next) physician whose charges might **not** be included in the hospital bill?

Physician Name:
GROUP
NAME/FIRSTNAME/MIDDLE/LAST/NATIONAL
PROVIDER ID

EF3 What is this physician's specialty?

Specialty:
_____ (IF OTHER SPECIFY:)

EF2 Did this doctor provide any of the following services for this event: radiology, anesthesiology, pathology, or surgery?

- 1 Radiology
- 2 Anesthesiology
- 3 Pathology
- 4 Surgery
- 5 None of the above
- 6 DON'T KNOW

EF5 How would you describe the role of this doctor for this medical event?

- Active Physician/Providing Direct Care 1
- Referring Physician 2
- Copied Physician 3
- Follow-up Physician 4
- Department Head 5
- Primary Care Physician 6
- Some Other Physician 7
- None of the above 8
- DON'T KNOW 9

(IF OTHER DESCRIBE)

What other type of physician?

EF6 ENTER ANY COMMENTS ABOUT THIS SBD, INCLUDING ADDITIONAL SERVICES TO THE ONE SELECTED IN EF2.

EVENT NOTES:

SECTION 8 – PATIENT ACCOUNTS – SERVICES/CHARGES

[PAGE 7 – PATIENT ACCOUNTS - SERVICES/CHARGES (1 of 2)]

Q6. 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 2014)?

FULL ESTABLISHED CHARGE OR CHARGE EQUIVALENT:

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?

CHECKPOINT: HAVE YOU BEEN ABLE TO DETERMINE THE FULL ESTABLISHED CHARGE?

YES, DID PROVIDE TOTAL CHARGE.....1
NO, CANNOT PROVIDE TOTAL CHARGE ...2

SECTION 9 – PATIENT ACCOUNTS – SOURCES OF PAYMENT

[PAGE 9 – PATIENT ACCOUNTS - SOURCES OF PAYMENT (1 of 1)]

<p>Q7. 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.</p> <p>SELECT ALL THAT APPLY</p> <p>[DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?</p> <p>[SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT REQUIRED]</p> <p>OTHER SPECIFY: PROBE FOR SOURCE OF FUNDS AND TYPE OF PLAN.</p> <p>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</p>	<p>SOURCE</p> <p>a. Patient or Patient's Family;</p> <p>b. Medicare;</p> <p>c. Medicaid;</p> <p>d. Private Insurance;</p> <p>e. VA/Champva;</p> <p>f. Tricare;</p> <p>g. Worker's Comp; or</p> <p>h. Something else? (IF SOMETHING ELSE: What was that?)</p>	<p>PAYMENT AMOUNT</p> <p>\$</p> <p>\$</p> <p>\$</p> <p>\$</p> <p>\$</p> <p>\$</p> <p>\$</p> <p>\$</p>
<p>Q8. [I show the total payment as TOTPAYM / I show the payment as undetermined. / I show the payment as TOTPAYM, although one or more payments are missing] Is that correct? IF NO, CORRECT ENTRIES ABOVE AS NEEDED.</p>	<p>TOTAL PAYMENTS</p>	<p>\$</p>

SECTION 10 – PATIENT ACCOUNTS – VERIFICATION OF PAYMENT

[PAGE 10 – PATIENT ACCOUNTS - VERIFICATION OF PAYMENT (1 of 1)]

<p>Q8a. 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?</p> <p>IF NECESSARY, READ BACK AMOUNT(S) RECORDED IN Q7.</p>	<p>YES, FINAL PAYMENTS RECORDED IN Q7</p> <p>NO</p>	<p>=1</p> <p>=2</p>
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SECTION 11 – PAYMENTS LESS THAN CHARGES (Q9_UNDERPAYMENT)

[Page 10 – SOURCES OF PAYMENT (1 of 1)]

PLC1. It appears that the total payments were less than the total charge. Is that because ...

a. There were adjustments or discounts	YES=1 NO=2
b. You are expecting additional payment	YES=1 NO=2
c. This was charity care or sliding scale	YES=1 NO=2
d. This was bad debt	YES=1 NO=2

ELIGVET2.

It appears that the total payment was less than the total charges. Is that because the person is an eligible veteran?

YES=1, NO=2

DCS: IF THE POC IS CONFUSED BY THE QUESTION, ANSWER THE QUESTION "NO"

SECTION 12 – PATIENT ACCOUNTS – DIFFERENCE BETWEEN PAYMENT AND CHARGES

[PAGE 11 – PATIENT ACCOUNTS - DIFFERENCE BETWEEN PAYMENT AND CHARGES (1 of 1)]

Are you expecting additional payment from:
IF THE ONLY PAYMENT FOR THIS EVENT
WAS A LUMP SUM, ANSWER "NO" TO ALL
OPTIONS

Expecting additional payment

- i. Patient or Patient's Family; YES=1, NO=2
- j. Medicare; YES=1, NO=2
- k. Medicaid; YES=1, NO=2
- l. Private Insurance; YES=1, NO=2
- m. VA/Champva; YES=1, NO=2
- n. Tricare; YES=1, NO=2
- o. Worker's Comp; or YES=1, NO=2
- p. Something else? YES=1, NO=2

(IF SOMETHING ELSE: What was that?)

ADJEXTRA

It appears that the total payment was more than the total charges. Is that correct?

YES=1
NO=2

DCS: IF THE ANSWER IS "NO" PLEASE GO BACK TO C5 (VERIFY TOTAL PAYMENTS) TO RECONFIRM CHARGES AND PAYMENTS AS NEEDED

SECTION 13 – PATIENT ACCOUNTS – RATES/CHARGES

[PAGE 12 – PATIENT ACCOUNTS – RATE/CHARGES (1 of 3)]

Q10. Can you tell me what the facility's full established daily rate for room and board and basic care was during this stay?

\$ _____ . _____

RATE PROVIDED.....1
RATE CHANGED DURING STAY.....2

[PAGE 14 – PATIENT ACCOUNTS – RATES/CHARGE (3 of 3)]

Q11. This stay for [PATIENT] that we are discussing lasted [STAYDAYS.] For how many days was the patient charged during this stay? Please give only the days during 2014.

_____ # DAYS

DAYS PROVIDED.....1
DAYS NOT REPORTED.....2

SECTION 14 – PATIENT ACCOUNTS – SOURCES OF PAYMENT 2

[PAGE 15 – PATIENT ACCOUNTS – SOURCES OF PAYMENT 2 (1 of 1)]

Q11a. 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?

SOURCE	PAYMENT AMOUNT
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?)	\$

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

Q11b. [I show the total payment as TOTPAYM / I show the payment as undetermined. / I show the payment as TOTPAYM, although one or more payments are missing] . Is that correct?
IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS \$

SECTION 15 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION WITH PAYMENTS

[PAGE 16 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION (1 of 7)]

Q12. (Perhaps it would be easier if you gave me information about payments by billing period.) What was the billing start date?

MO DY YR

Q12a. What was your billing end date?

MO DY YR

[PAGE 17 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION (2 of 7)]

Q12-1. BILLING PERIOD IS BETWEEN BPBEGM#/ BPBEGD#/ BPBEGY# and BPENDM#/BPENDD#/ BPENDY#
Thanks, that means there were _____ days in your billing period. Between (____and____), how many days was the patient charged for room, board and basic care?

_____ # BILLED DAYS

[PAGE 18 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION (2 of 7)]

Q12-1a. The number of days the patient was charged for room, board and basic care was (DAYSBILLED#) days and that is less than the number of days in the billing period, (DAYSBILLPER#). Do you know why?

[PAGE 19 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION (3 of 7)]

Q12-2. Between (____ and ____), what was the private pay rate for room, board and basic care (PATIENT NAME) received? If the rate changed, please give me the initial rate.

\$_____.

12-3. How many days was that rate applied during this billing period?

_____ # DAYS

[PAGE 20 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION (4 of 7)]

12-Intro. I see that the rate of (BASEPAYRATE#) applied for (BASERATEDAY#) days, although your billing period was (DAYSBILLED#) long. I need to ask some questions to help account for the entire billing period.

12-2A. Between (____ and ____), what other private pay rate applied to the basic care that (PATIENT NAME) received?

\$_____.

12-3A. On what date did this rate of (____) begin?

____/____/____
MO DY YR

12-4A. During this billing period, how many days was that rate of (OTHBASERATE#) applied?

DAYS: _____

12-5A. Why did the rate change? CODE ONLY ONE.

- LEVEL OF CARE 1
- PATIENT DISCHARGED TO HOSPITAL 2
- PATIENT DISCHARGED TO COMMUNITY 3
- PATIENT DISCHARGED TO OTHER FACILITY 4
- RATE INCREASE 5
- ROOM CHANGE 6
- OTHER, SPECIFY 7

[PAGE 21 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION (5 of 7)]

12-7 Is (RATE IN 12-2a) the private pay rate that applied at the end of the billing period?

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

[PAGE 22 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION (6 of 7)]

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

\$_____.

SECTION 16 – PATIENT ACCOUNTS – SOURCES OF PAYMENT 3

[PAGE 24 – PATIENT ACCOUNTS – SOURCES OF PAYMENT (1 of 1)]

Q13. 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

SOURCE	PAYMENT AMOUNT
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?)	\$

Q13a. [I show the total payment as TOTPAYM / I show the payment as undetermined. / I show the payment as TOTPAYM, although one or more payments are missing]
IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS \$

SECTION 17 – PATIENT ACCOUNTS – ANCILLARY CHARGES

[PAGE 25 – PATIENT ACCOUNTS – ANCILLARY CHARGES (1 of 1)]

Q14. Did (PATIENT NAME) 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

SECTION 18 – PATIENT ACCOUNTS – TOTAL ANCILLARY CHARGES

[PAGE 26 – PATIENT ACCOUNTS – TOTAL ANCILLARY CHARGES (1 of 1)]

Q15. 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.

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).

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 total of the charge equivalents for health-related ancillary care during this stay?

TOTAL CHARGES: \$ _____.

- YES, PROVIDED1
- CAN'T SEPARATE HEALTH AND NON-HEALTH ANCILLARY CHARGES.....2
- CAN'T GIVE TOTAL HEALTH-RELATED ANCILLARY CHARGES.....3

SECTION 19 – PATIENT ACCOUNTS – SOURCES OF PAYMENT 4

[PAGE 27 – PATIENT ACCOUNTS – SOURCES OF PAYMENT (1 of 1)]

Q16. 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?) \$

Q17. [I show the total payment as _____ / I show the payment as undetermined. / I show the payment as _____, although one or more payments are missing] Is that correct?
IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS \$

SECTION 20 – PATIENT ACCOUNTS – VERIFICATION OF PAYMENT 2

[PAGE 28 – PATIENT ACCOUNTS - VERIFICATION OF PAYMENT (1 of 1)]

Q17a. 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 [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
 NO..... 2

SECTION 21 – PAYMENTS LESS THAN CHARGES (Q18_UNDERPAYMENT)

[Page 10 – SOURCES OF PAYMENT (1 of 1)]

PLC2. It appears that the total payments were less than the total charge. Is that because ...

- a. There were adjustments or discounts YES=1 NO=2
- b. You are expecting additional payment YES=1 NO=2
- c. This was charity care or sliding scale YES=1 NO=2
- d. This was bad debt YES=1 NO=2

ELIGVET2_2

It appears that the total payment was less than the total charges. Is that because the person is an eligible veteran?

YES=1,
 NO=2

DCS: IF THE POC IS CONFUSED BY THE QUESTION, ANSWER THE QUESTION “NO”

SECTION 22 – PATIENT ACCOUNTS – DIFFERENCE BETWEEN PAYMENT AND CHARGES 2

[PAGE 29 – PATIENT ACCOUNTS - DIFFERENCE BETWEEN PAYMENT AND CHARGES (1 of 1)]

[Redacted]

Expecting additional payment

Are you expecting additional payment from:
 IF THE ONLY PAYMENT FOR THIS EVENT WAS A
 LUMP SUM, ANSWER “NO” TO ALL OPTIONS

- i. Patient or Patient's Family; YES=1, NO=2
 - j. Medicare; YES=1, NO=2
 - k. Medicaid; YES=1, NO=2
 - l. Private Insurance; YES=1, NO=2
 - m. VA/Champva; YES=1, NO=2
 - n. Tricare; YES=1, NO=2
 - o. Worker's Comp; or YES=1, NO=2
 - p. Something else? YES=1, NO=2
- (IF SOMETHING ELSE: What was that?)

ADJEXTRA_2

It appears that the total payments were more than the total charges. Is that correct?

[Redacted]

YES=1, NO=2

DCS: IF THE ANSWER IS “NO” PLEASE GO BACK TO
 C5 (VERIFY TOTAL PAYMENTS) TO RECONFIRM
 CHARGES AND PAYMENTS AS NEEDED

SECTION 23 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION 2

[PAGE 30 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION (1 of 1)]

Q19. Perhaps it would be easier if you gave me the information about **ancillary charges** by billing period.

a. First, what was the start date of the first billing period in which (PATIENT NAME) was a patient? ENTER MONTH ONLY IF BILLING PERIOD IS MONTHLY.

(MONTH)

or

(START DATE)

b. And what was the 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.

\$_____.

SECTION 24 – PATIENT ACCOUNTS – SOURCES OF PAYMENT 5

[PAGE 31 – PATIENT ACCOUNTS – SOURCES OF PAYMENT (1 of 2)]

Q20. From which of the following sources did the facility receive payments for ancillary charges for the billing period that began (BILLING PERIOD DATE) 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?) _____ \$ _____.

Q20(h) – Menu for “Something else?”;
 Auto or Accident Insurance
 CHDP/CHIP
 Indian Health Service
 State Public Mental Plan
 State/County Local program
 Other

[PAGE 32 – PATIENT ACCOUNTS – SOURCES OF PAYMENT (2 of 2)]

Q20a. I show the total payment as [TOTAL]. Is that correct?
 IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

SECTION 25 – PATIENT ACCOUNTS – capitated basis

[PAGE 33 – PATIENT ACCOUNTS – CAPITATED BASIS (1 of 4)]

CAPITATED BASIS

- | | | |
|--|--|-------------|
| Q21a. What kind of insurance plan covered the patient for this stay? Was it: | a. Medicare; | YES=1, NO=2 |
| | b. Medicaid; | YES=1, NO=2 |
| | c. Private Insurance; | YES=1, NO=2 |
| | d. VA/Champva; | YES=1, NO=2 |
| | e. Tricare; | YES=1, NO=2 |
| | f. Worker’s Comp; or | YES=1, NO=2 |
| | g. Something else?
(IF SOMETHING ELSE:
What was that?) | YES=1, NO=2 |
- [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.

Q21a(g) –
 “Other Specify” menu
 Auto or Accident Insurance
 CHDP/CHIP
 Indian Health Service
 State Public Mental Plan
 State/County Local program
 Other

Q21b. What was the monthly payment from that plan? \$ _____.

Q21c. Was there a co-payment for any part of this stay?
 YES=1,
 NO=2

[PAGE 34 – PATIENT ACCOUNTS – CAPITATED BASIS (2 of 4)]

Q21d. How much was the co-payment? \$ _____.

per DAY..... 1
WEEK..... 2
MONTH..... 3
OTHER..... 4
SPECIFY: _____

Q21e. For how many (days/weeks/months/other) _____#
was the co-payment paid?

Q21f. Who paid the co-payment? Was it:

<p>[DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?</p> <p>OTHER SPECIFY: PROBE FOR SOURCE OF FUNDS AND TYPE OF PLAN.</p>	<p>a. Patient or Patient's Family; b. Medicare; c. Medicaid; d. Private Insurance; or e. Something else? (IF SOMETHING ELSE: What was that?)</p>	<p>YES=1, NO=2 YES=1, NO=2 YES=1, NO=2 YES=1, NO=2 YES=1, NO=2</p>
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Q21f(e) – Include the following options in a drop down menu for the “Other Specify”;

- Auto or Accident Insurance
- CHDP/CHIP
- Indian Health Service
- State Public Mental Plan
- State/County/Local program
- Other

[PAGE 35 – PATIENT ACCOUNTS – CAPITATED BASIS (3 of 4)]

Q21g. Do your records show any other payments _____
for this stay? YES=1, NO=2

[PAGE 36 – PATIENT ACCOUNTS – CAPITATED BASIS (4 of 4)]

Q21h. 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.

	SOURCE	PAYMENT AMOUNT
<p>SELECT ALL THAT APPLY</p> <p>[DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?</p> <p>OTHER SPECIFY: PROBE FOR SOURCE OF FUNDS AND TYPE OF PLAN.</p>	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?)	\$

21h (h) – Include the following options in a drop down menu for the “Other Specify”;

- Auto or Accident Insurance
- CHDP/CHIP
- Indian Health Service
- State Public Mental Plan
- State/County/Local program
- Other

FINISH SCREEN

PRESS VALIDATE TO COMPLETE THIS EVENT FORM.