Form Approved
OMB No. 0935-0118
Exp. Date 12/31/2015

ATTACHMENT 94

MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

DATA FORM

FOR

PHARMACIES

FOR

REFERENCE YEAR 2014

Q1. Date Filled

| | MONTH | DAY | YEAR |

Q2. Prescription information will be identified using:

1 = NDC
2 = Drug Name, Strength/Unit, and Dosage Form

NOTE: TRY TO OBTAIN NDC. USE DRUG NAME ONLY IF NDC NOT AVAILABLE.

Q2a. NDC

ENTER 11-DIGIT NDC WITHOUT DASHES OR SPACES.

NDC IS UNKNOWN OR REFUSED, RETURN TO PREVIOUS SCREEN AND SELECT **DRUG NAME** OPTION

Q3a. Quantity:

Q4. How many days were supplied?

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

Q5. **Patient Payment:** $

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

∴ PRESCRIPTION INFO/Path_NDC

Q3a.   **Quantity**

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

Q5.   **Patient Payment**

Q5a.   **Were there any 3rd party payers?**   -Select- ▾ F6 F7 F8

Q2b.   Drug Name:

Q2b_1 Check this box to indicate Durable Medical Equipment ●

Q2c.   Strength

    Q2d.   Unit:

    Q2c1.   Strength:

    Q2d2.   Unit:

    Q2e.   Dosage Form:

       Other Specify:

    Q3a.   Quantity:

    Q3b Unit:

    OTHER, PLEASE SPECIFY

    Q4.   How many days were supplied?

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

    Q5.   **Patient Payment:** $

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

· PRESCRIPTION INFO/Path_DrugName

Q2b. **Drug Name** | ⌐6 ⌐7 ⌐3

   ☐ **Compound drug?**

   ☐ **Durable Medical Equipment (DME)?**
     IF DURABLE MEDICAL EQUIPMENT GO TO Q3a

Q2c. **Strength**   ⌐6 ⌐7 ⌐3
Q2d. **Unit**   -Select One- ⌄ ⌐6 ⌐7 ⌐3
   Other, specify   ⌐6 ⌐7 ⌐3
Q2c2. **Strength 2**   ⌐6 ⌐7 ⌐3
Q2d2. **Unit 2**   -Select One- ⌄ ⌐6 ⌐7 ⌐3
   Other, specify   ⌐6 ⌐7 ⌐3
Q2e. **Dosage Form**   -Select One -   ⌄ ⌐6 ⌐7 ⌐3
   Other, specify   ⌐6 ⌐7 ⌐3
Q3a. **Quantity**   ⌐6 ⌐7 ⌐3
Q3b. **Quantity Unit** -Select One- ⌄ ⌐6 ⌐7 ⌐3
   Other, specify   ⌐6 ⌐7 ⌐3
Q4.   **Days Supplied?**   ⌐6 ⌐7 ⌐3
Q5.   **Patient Payment**   ⌐6 ⌐7 ⌐3

Q5a. **Any 3rd party payers?**

  ◯ ☐ YES
  ◯ ☐ NO

FAQ LINK AND/OR JOBAID FOR INSTRUCTIONS PREVIOUSLY ON SCREEN

FINAL SCREEN

Q6. **Type of 3rd Party Payer**
Other Specify Source

Q7. **3rd Party Payment** $

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

Any more 3rd Party Payers?
    1   YES
    2   NO

Vision Pharmacy (1317257)

PAYMENT INFO/Q6_3rdPartyPayers/Q6

Third Party Payer   Amount

Type of 3rd Party Payer

SOURCE   OTHER SPECIFY
-Select One-   F6 F7 F8   F6 F7 F

3rd Party Payment $ F6 F7 F8

Any more 3rd party payers?

   ◯ ☐ YES
   ◯ ☐ NO

FINISH SCREEN
PRESS VALIDATE TO COMPLETE THIS EVENT FORM.