Attachment 96

MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

EVENT FORM

FOR

INSTITUTIONAL PROVIDERS
(NON-HOSPITAL FACILITIES)

FOR

REFERENCE YEAR 2017

SECTION 1 – OMB

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, 5600 Fishers Lane, Rockville, MD 20857.)

SECTION 2 – MEDICAL RECORDS – EVENT DATE

OMB Statement

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

NotCurrYr

YOU ENTERED DATES FOR A SINGLE STAY THAT INCLUDED ALL OF 2017.

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

IF THIS IS CORRECT PRESS “NEXT.”

SECTION 3 – MEDICAL RECORDS – DIAGNOSES

A3. I need the diagnoses for this stay. I would prefer the ICD-10 codes (or DSM-5 codes), if they are available.

IF CODES ARE NOT USED, RECORD DESCRIPTIONS.

[SYSTEM WILL ALLOW FOR A MAXIMUM OF 5 ICD-10 CODES TO BE COLLECTED]

CODE DESCRIPTION

SECTION 4 – MEDICAL RECORDS – SBD

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.

PROBE FOR MORE THAN ONE RADIOLOGIST, ANETHESIOLOGIST, 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.

SEPARATELY BILLING DOCTORS FOR THIS EVENT……1

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

DO NOT HAVE THIS INFORMATION……..3

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?

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

SBD REAL-TIME PROMPTING

SBDPR1: A diagnosis that you mentioned often involves a (FILL SPECIALTY) and we did not record such persons in the earlier questions about separately billing doctors. Do your records indicate that a [FILL_SPECIALTY] was associated with this patient event?

YES=1
NO=2

SBDPR3: PROBE WHY THERE WAS NO SBD OF THE EXPECTED TYPES FOR THIS EVENT.

Create a text box that allows 100 characters.

SECTION 7 – PATIENT ACCOUNTS – REIMBURSEMENT TYPE

Q5. 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. This is also called Per Member Per Month

IF IN DOUBT, CODE FEE-FOR-SERVICE.

FEE-FOR-SERVICE BASIS 1
CAPITATED BASIS..... 2

SECTION 8 – PATIENT ACCOUNTS – SERVICES/CHARGES

Q6_1. 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?

O 1 YES
O 2 NO

Q6_2. CAN YOU SEPARATE PAYMENTS FOR ANCILLARY SERVICES FROM PAYMENTS FOR ROOM/BOARD/BASIC CARE?

O 1 YES
O 2 NO
O 3 NO, ANCILLARY CHARGES WERE ADJUSTED 100%

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 2017)?

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?

FULL ESTABLISHED CHARGE OR CHARGE EQUIVALENT:

$

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

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

Q6a. 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

SECTION 9 – PATIENT ACCOUNTS – SOURCES OF PAYMENT

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.

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?)	$

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.

TOTAL PAYMENTS **$**

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, PAYMENTS < CHARGES - 3 (GO TO PLC1)
NO, PAYMENTS > CHARGES - 4 (GO TO ADJEXTRA**)**

SECTION 10 – PATIENT ACCOUNTS – VERIFICATION OF PAYMENT

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?

YES, FINAL PAYMENTS RECORDED IN Q7 AND Q8 =1

NO =2

IF NECESSARY, READ BACK AMOUNT(S) RECORDED IN Q7.

SECTION 11 – PAYMENTS LESS THAN CHARGES

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
e. Person is an eligible veteran	YES=1 NO=2

SECTION 12 – PATIENT ACCOUNTS – DIFFERENCE BETWEEN PAYMENT AND CHARGES

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

C9_Additional, Question Q9_additional

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?

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

YES=1, NO=2

SECTION 13 – PATIENT ACCOUNTS – RATES/CHARGES

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

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 2017.

_____ # DAYS

DAYS PROVIDED.....1

DAYS NOT REPORTED.....2

SECTION 14 – PATIENT ACCOUNTS – SOURCES OF PAYMENT 2

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?

[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?)	$

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

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

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

_____# BILLED DAYS

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?

_____

Q12-2. Between (BPBEGM#/ BPBEGD#/ BPBEGY# and BPENDM#/BPENDD#/ BPENDY#), 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

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 (BPBEGM#/ BPBEGD#/ BPBEGY# and BPENDM#/BPENDD#/ BPENDY#), what other private pay rate applied to the basic care that (PATIENT NAME) received?

$_____.____

12-3A. On what date did this rate of (OTHBASERATE#) 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

_____

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

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

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

$_____._____

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 **$**

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

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, PROVIDED ……1

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

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 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 **$**

BOX 2

DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?

YES, AND ALL PAID BY PATIENT OR PATIENT'S FAMILY…… 1 (GO TO Exit
YES, OTHER PAYERS…… 2 (GO TO Q17a)
NO, PAYMENTS < CHARGES - 3 (GO TO PLC1)
NO, PAYMENTS > CHARGES - 4 (GO TO ADJEXTRA_2**)**

SECTION 20 – PATIENT ACCOUNTS – VERIFICATION OF PAYMENT 2

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 [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

NO…… 2

SECTION 21 – PAYMENTS LESS THAN CHARGES *(NEW SECTION, Q18_UNDERPAYMENT)*

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
e. Person is an eligible veteran	YES=1 NO=2

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

C18_Additional, Question Q18_additional

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_2
It appears that the total payments were more than the total charges. Is that correct?

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

YES=1, NO=2

SECTION 23 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION 2

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

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?) _____	$_____.____

Q20a. [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.

SECTION 25 – PATIENT ACCOUNTS – capitated basis

CAPITATED BASIS

Q21a. 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.

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

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

Q21d. 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: _____	

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

Q21f. 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.

a. Patient or Patient's Family;	YES=1, NO=2
b. Medicare;	YES=1, NO=2
c. Medicaid;	YES=1, NO=2
d. Private Insurance; or	YES=1, NO=2
e. Something else? (IF SOMETHING ELSE: What was that?)	YES=1, NO=2

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

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.

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.

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?)	

FINISH SCREEN

PRESS VALIDATE TO COMPLETE THIS EVENT FORM.