

ATTACHMENT 98
MEDICAL EXPENDITURE PANEL SURVEY
MEDICAL PROVIDER COMPONENT
DATA FORM
FOR
PHARMACIES
FOR
REFERENCE YEAR 2017

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.)

Q1. Date Filled

[OMB Statement link](#)

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

[OMB Statement](#)

Q1. Date Filled

MONTH

DAY

YEAR

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

Q2a. NDC

ENTER 11-DIGIT NDC WITHOUT DASHES OR SPACES

NDC ROUTE
IF Q2 = 1 (NDC COLLECTED)

The NDC you specified:

NDC: [FILL NDC]

DESCRIPTION: [SMZ/TMP DS TAB 800-160]

DCS: Please confirm that the drug names matches what is in the record (if specified in the record). If it does not, please click on Previous and correct the NDC number entered.

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	<input type="text"/>	F6 F7 F8
Q4. How many days were supplied?	<input type="text"/>	F6 F7 F8
Q5. Patient Payment	<input type="text"/>	F6 F7 F8
Q5a. Were there any 3rd party payers?	-Select- ▾	F6 F7 F8

Next Breakoff Validate Return to Test

DRUG NAME ROUTE
IF Q2 = 3 (DRUG NAME COLLECTED)

Q2b. Drug Name:

Q2b_1

Compound drug? •

Durable Medical Equipment •

IF DURABLE MEDICAL EQUIPMENT GO TO Q3a***

MJ? •

IF MJ GO TO Q3a***

Q2c. Strength

Q2d. Unit:

Q2c1. Strength 2:

Q2d2. Unit 2:

Q2e. Dosage Form:

Q3a. Quantity:

Q3b Unit:

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 F6 F7 F8

Compound drug?

Durable Medical Equipment (DME)?

IF DURABLE MEDICAL EQUIPMENT GOTO Q3a***

MJ ?

IF MJ GOTO Q3a*** F6 F7 F8

Q2c. Strength F6 F7 F8

Q2d. Unit F6 F7 F8

Other, specify F6 F7 F8

Q2c2. Strength 2 F6 F7 F8

Q2d2. Unit 2 F6 F7 F8

Other, specify F6 F7 F8

Q2e. Dosage Form F6 F7 F8

Other, specify F6 F7 F8

Q3a. ***Quantity F6 F7 F8

Q3b. ***Quantity Unit F6 F7 F8

Other, specify F6 F7 F8

Q4. ***Days Supplied? F6 F7 F8

Q5. ***Patient Payment F6 F7 F8

Q5a. Any 3rd party payers?

1 YES

2 NO

F6 F7 F8

« Previous

Next »

Breakoff »

✔ Validate

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

FINISH SCREEN

PRESS VALIDATE TO
COMPLETE THIS EVENT FORM.