Modification of Diet in Renal Disease Study
ECONOMIC INFORMATION FORM

This form should be completed at the Screening Visit and annually thereafter for patients continuing on in the study.

This health insurance information requested is for HCFA billing purposes. Additional information regarding billing is located in the Manual of Operations in the chapter on Billing.

Complete the form and retain a copy for your Center's records. Send the original to HCFA.

The subscriber is the person purchasing the policy. If no number is given, it is usually the social security number.

For DCC Use Only
Rev. 2 10/4/90

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This form should be completed at the Screening visit and annually thereafter. The original should be sent to HCFA.

FORM # 2 9

1. Patient Identification Number ..... ___ ___ ___ ___ ___ ___
2. Patient Name Code ..... ___ ___ ___ ___
3. Clinical Center ..... ___ ___
4. Date of visit ..... ___ ___/ ___ ___/ ___ ___
5. a. Name of patient ..... _____

   b. Social Security Number ..... ___ ___ ___ - ___ ___ - ___ ___ ___ ___
6. Does the patient have health insurance? (1 = yes, 2 = no) ..... ___

If NO, skip to Item 7.
If YES, complete "(1)" through "(4)" for each insurance plan, "A" through "C".

A. 1. Type of Plan ..... ___
   1 = Employee Group Plan
   2 = Individual Plan
   3 = Other Group Plan (_____)

   2. Name of insurance company (not employer)

   _____

   3. Subscriber
      a. Name _____

      b. Number _____

      c. Is the patient the subscriber? (1 = yes, 2 = no) ..... ___

   4. Is this an HMO (health maintenance organization) type of coverage (i.e., patient limited to a specific set of health care providers)? (1 = yes, 2 = no) ..... ___

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If more than one insurance plan, continue. Otherwise skip to item 7.

B. 1. Type of Plan.....___
   1 = Employee Group Plan
   2 = Individual Plan
   3 = Other Group Plan (_____)

   2. Name of insurance company (not employer)

   _____

   3. Subscriber
      a. Name _____

      b. Number_____

      c. Is the patient the subscriber? (1 = yes, 2 = no).....___

   4. Is this an HMO (health maintenance organization) type of coverage (i.e., patient limited to a specific set of health care providers)? (1 = yes, 2 = no).....___

If more than two insurance plans, continue. Otherwise skip to item 7.

C. 1. Type of Plan.....___
   1 = Employee Group Plan
   2 = Individual Plan
   3 = Other Group Plan (_____)

   2. Name of insurance company (not employer)

   _____

   3. Subscriber
      a. Name _____

      b. Number_____

      c. Is the patient the subscriber? (1 = yes, 2 = no).....___

   4. Is this an HMO (health maintenance organization) type of coverage (i.e., patient limited to a specific set of health care providers)? (1 = yes, 2 = no).....___

7. If the patient has not indicated Medicare or Medicaid as a part of his/her health insurance coverage in item 6 above, ask the following:

   a. Has the patient applied for Medicare? (1 = yes, 2 = no).....___

   b. Has the patient applied for Medicaid? (1 = yes, 2 = no).....___

8. a. Is the patient receiving "Disability income" from Social Security? (1 = yes, 2 = no).....___

   b. If yes, for how many months?.....___ ___ ___

   c. If yes, how much per month.....$ ___ ___ ___ ___ . ___ ___

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101. Date this form completed..... ___ ___/ ___ ___/ ___ ___

102. Certification number of person filling out this form ..... ___ ___ ___ ___ ___

103. Date form entered..... ___ ___/ ___ ___/ ___ ___

104. Certification number of data entry person ..... ___ ___ ___ ___ ___

Retain a copy of this form for your files. Send the original to the Health Care Finance Administration. Please use MDRD Study mailing labels:

Health Care Finance Administration
Office of Research and Demonstrations
P.O. Box 11972
Baltimore, Maryland 21207-0972
ATTENTION: Research and Demonstrations
Systems Support MDRD STUDY
