

**National Hospital Care Survey Facility Questionnaire**  
**Part C: Hospital Primary Contact Interview**

**Section I. Hospital Information**

1. Is this hospital a subsidiary of a larger company or part of a hospital network?

Yes → *Please indicate the name of the larger company or hospital network:*

\_\_\_\_\_

No

Don't Know

2. Are other hospitals covered under your State license?

Yes → *Please list name(s) of hospitals:*

\_\_\_\_\_

No

Don't Know

3. When this hospital submits data to the State or the hospital association, do they include information solely on this facility or are they combined with another facility(ies)?

Solely on this facility

Combined with another facility → *Please provide the name of the other facility:*

\_\_\_\_\_

Don't know

4. What is the number of currently staffed beds? Please let me know if the number you provide is an estimate or the actual figure:

Total staffed beds: \_\_\_\_\_

Estimate    Actual Figure

Bassinets: \_\_\_\_\_

Estimate    Actual Figure

Skilled or intermediate nursing beds: \_\_\_\_\_

Estimate    Actual Figure

5. What is the primary service type of this hospital?

- |  |   |
|--|---|
| <input type="checkbox"/> General Acute Care            | <input type="checkbox"/> Children's hospital          |
| <input type="checkbox"/> Surgical                      | <input type="checkbox"/> Cancer                       |
| <input type="checkbox"/> Long term care acute          | <input type="checkbox"/> Obstetrics and gynecology    |
| <input type="checkbox"/> Eye, ear, nose, and throat    | <input type="checkbox"/> Alcohol/drug dependency only |
| <input type="checkbox"/> Psychiatric only facility     | <input type="checkbox"/> Rehabilitation only facility |
| <input type="checkbox"/> Heart                         | <input type="checkbox"/> Orthopedic                   |
| <input type="checkbox"/> Other → Please specify: _____ |   |

6. Do you anticipate any significant changes in your discharge volume in the coming year (for example, opening a cardiac wing or closing a birthing center)?

- Yes → *Please explain* \_\_\_\_\_  
 No

**Section II. Data Transfer**

7. Is it possible for your staff to electronically transmit UB-04 administrative claims data for all discharges from your hospital?

- Yes  
 No  
 Don't know

8. Will the data you provide us include only discharges from your hospital?

- Yes → *Skip to Q.10*  
 No → *Please provide name(s) of hospital(s) also included:*

\_\_\_\_\_

9. Is it possible to identify the discharges from your hospital as opposed to discharges from another hospital?

- Yes → *How?* \_\_\_\_\_  
 No

10. Can all inpatient claims be provided to NCHS, specifically "Type of Bill" codes 011X and 012X?

Yes → *Skip to text* ↴

No

11. Can all UB-04 claims, both inpatient and outpatient, be provided?

Yes

No → *What can you provide?* \_\_\_\_\_

[Note to EI: *contact NCHS about this hospital*].

**This next question relates to reimbursement to your hospital for its participation in the survey. Your hospital will receive a onetime set up fee of \$500 and additional \$500 for every year of participation in the survey.**

12. Can you tell me to whom the checks should be sent?

Yes →

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

No → **Is there someone else that I should speak with about getting this information?**

Name: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_