

# Medicare Provider Experience Survey

**Si prefiere este cuestionario en español, por favor envíenos un correo electrónico a [INSERT VENDOR EMAIL] o llame al [INSERT VENDOR PHONE].**

## SURVEY INSTRUCTIONS

This survey asks about you and the health care you received in the last 6 months. Answer each question thinking about yourself. Please take the time to complete this survey. Your answers are very important to us. Please return the survey with your answers in the enclosed postage-paid envelope to [VENDOR NAME].

Answer all the questions by putting an “X” in the box to the left of your answer, like this:

Yes



Be sure to read all the answer choices given before marking your answer.

You are sometimes told not to answer some questions in this survey. When this happens, you will see an arrow with a note that tells you what question to answer next, like this:

Arrow pointing to the right **If No, go to 3.** See the example below:

### EXAMPLE

1. Do you wear a hearing aid now?

check box Yes

 No Arrow pointing to the right **If No, go to 3**

1. How long have you been wearing a hearing aid?

check box Less than one year

check box 1 to 3 years

check box More than 3 years

check box I don’t wear a hearing aid

1. In the last 6 months, did you have any headaches?

 Yes

check box No

#### Your Provider

1. Our records show that you visited the provider named below in the last 6 months.

PRFNAME\_VIS PRLNAME\_VIS PRTITLE\_VIS

Is that right?

check box Yes

check box No Arrow pointing to the right **If No, go to 26**

The questions in this survey will refer to the provider named in Question 1 as “this provider.” Please think of that person as you answer the survey.

1. Is this the provider you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?

check box Yes

check box No

1. How long have you been going to this provider?

check box Less than 6 months

check box At least 6 months but less than 1 year

check box At least 1 year but less than 3 years

check box At least 3 years but less than 5 years

check box 5 years or more

**Your Care from This Provider   
in the Last 6 Months**

These questions ask about **your own** health care. Do **not** include care you got when you stayed overnight in a hospital. Do **not** include the times you went for dental care visits.

1. In the last 6 months, how many times did you visit this provider to get care for yourself?

check box None Arrow pointing to the right **If None, go to 26**

check box 1 time

check box 2

check box 3

check box 4

check box 5 to 9

check box 10 or more times

1. In the last 6 months, did you contact this provider’s office to get an appointment for an illness, injury or condition that **needed care right away**?

check box Yes

check box No Arrow pointing to the right **If No, go to 7**

1. In the last 6 months, when you contacted this provider’s office to get an appointment for **care you needed right away**, how often did you get an appointment as soon as you needed?

check box Never

check box Sometimes

check box Usually

check box Always

1. In the last 6 months, did you make any appointments for a **check-up or routine care** with this provider?

check box Yes

check box No Arrow pointing to the right **If No, go to 9**

1. In the last 6 months, when you made an appointment for a **check-up or routine care** with this provider, how often did you get an appointment as soon as you needed?

check box Never

check box Sometimes

check box Usually

check box Always

1. In the last 6 months, did you contact this provider’s office with a medical question during regular office hours?

check box Yes

check box No Arrow pointing to the right **If No, go to 11**

1. In the last 6 months, when you contacted this provider’s office during regular office hours, how often did you get an answer to your medical question that same day?

check box Never

check box Sometimes

check box Usually

check box Always

1. In the last 6 months, did you contact this provider’s office with a medical question after regular office hours?

check box Yes

check box No Arrow pointing to the right **If No, go to 13**

1. In the last 6 months, when you contacted this provider’s office after regular hours, how often did you get an answer to your medical question as soon as you needed?

check box Never

check box Sometimes

check box Usually

check box Always

1. In the last 6 months, how often did this provider explain things in a way that was easy to understand?

check box Never

check box Sometimes

check box Usually

check box Always

1. In the last 6 months, how often did this provider listen carefully to you?

check box Never

check box Sometimes

check box Usually

check box Always

1. In the last 6 months, how often did this provider seem to know the important information about your medical history?

check box Never

check box Sometimes

check box Usually

check box Always

1. In the last 6 months, how often did this provider show respect for what you had to say?

check box Never

check box Sometimes

check box Usually

check box Always

1. In the last 6 months, how often did this provider spend enough time with you?

check box Never

check box Sometimes

check box Usually

check box Always

1. In the last 6 months, did this provider order a blood test, x-ray, or other test for you?

check box Yes

check box No Arrow pointing to the right **If No, go to 20**

1. In the last 6 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider’s office follow up to give you those results?

check box Never

check box Sometimes

check box Usually

check box Always

1. In the last 6 months, did you and this provider talk about starting or stopping a prescription medicine?

check box Yes

check box No Arrow pointing to the right **If No, go to 22**

1. When you and this provider talked about starting or stopping a prescription medicine, did this provider ask what you thought was best for you?

check box Yes

check box No

1. In the last 6 months, did you and this provider talk about how much of your personal health information you wanted shared with your family or friends?

check box Yes

check box No

1. Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

check box 0 Worst provider possible

check box 1

check box 2

check box 3

check box 4

check box 5

check box 6

check box 7

check box 8

check box 9

check box 10 Best provider possible

**Clerks and Receptionists at   
This Provider’s Office**

1. In the last 6 months, how often were clerks and receptionists at this provider’s office as helpful as you thought they should be?

check box Never

check box Sometimes

check box Usually

check box Always

1. In the last 6 months, how often did clerks and receptionists at this provider’s office treat you with courtesy and respect?

check box Never

check box Sometimes

check box Usually

check box Always

**Your Care from Specialists   
in the Last 6 Months**

1. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. Is the **provider named in Question 1** of this survey a specialist?

check box Yes Arrow pointing to the right **If Yes, please include this provider as you answer these questions about specialists**

check box No

1. In the last 6 months, did you try to make any appointments with specialists?

check box Yes

check box No Arrow pointing to the right **If No, go to 29**

1. In the last 6 months, how often was it easy to get appointments with specialists?

check box Never

check box Sometimes

check box Usually

check box Always

**All Your Care in the Last 6 Months**

These questions ask about **all your** health care. Include all the providers you saw for health care in the last 6 months. Do **not** include the times you went for dental care visits.

1. Your health care team includes all the doctors, nurses, and other people you see for health care. In the last 6 months, did you and anyone on your health care team talk about a healthy diet and healthy eating habits?

check box Yes

check box No

1. In the last 6 months, did you and anyone on your health care team talk about the exercise or physical activity you get?

check box Yes

check box No

1. In the last 6 months, did you take any prescription medicine?

check box Yes

check box No Arrow pointing to the right **If No, go to 34**

1. In the last 6 months, how often did you and anyone on your health care team talk about all the prescription medicines you were taking?

check box Never

check box Sometimes

check box Usually

check box Always

1. In the last 6 months, did you and anyone on your health care team talk about how much your prescription medicines cost?

check box Yes

check box No

1. In the last 6 months, did you have family or friends involved in your care?

check box Yes

check box No Arrow pointing to the right **If No, go to 37**

1. In the last 6 months, did this provider involve your family or friends in discussions about your health care as much as you wanted?

check box Yes

check box No

1. In the last 6 months, did your family members or friends get as much emotional support as they wanted from this provider?

check box Yes

check box No

1. In the last 3 months, did you have any feelings of anxiety or sadness?

check box Yes

check box No Arrow pointing to the right **If No, go to 39**

1. In the last 3 months, did you get as much help as you wanted for your feelings of anxiety or sadness?

check box Yes, definitely

check box Yes, somewhat

check box No

1. In the last 3 months, did you have any pain?

check box Yes

check box No Arrow pointing to the right **If No, go to 41**

1. In the last 6 months, did this provider give you as much help as you wanted for your pain?

check box Yes

check box No

1. Did someone from this provider’s office ever talk with you about what you should do during a health emergency?

check box Yes

check box No

**About You**

1. In general, how would you rate your overall health?

check box Excellent

check box Very good

check box Good

check box Fair

check box Poor

1. In general, how would you rate your overall **mental or emotional** health?

check box Excellent

check box Very good

check box Good

check box Fair

check box Poor

1. In the **last 12 months**, have you seen a doctor or other health provider 3 or more times for the same condition or problem?

check box Yes

check box No Arrow pointing to the right **If No, go to 46**

1. Is this a condition or problem that has lasted for at least 3 months?

check box Yes

check box No

1. Do you now need or take medicine prescribed by a doctor?

check box Yes

check box No Arrow pointing to the right **If No, go to 48**

1. Is this medicine to treat a condition that has lasted for at least 3 months?

check box Yes

check box No

1. What is your age?

check box 18 to 24

check box 25 to 34

check box 35 to 44

check box 45 to 54

check box 55 to 64

check box 65 to 69

check box 70 to 74

check box 75 to 79

check box 80 to 84

check box 85 or older

1. Are you male or female?

check box Male

check box Female

1. What is the highest grade or level of school that you have completed?

check box 8th grade or less

check box Some high school, but did not graduate

check box High school graduate or GED

check box Some college or 2-year degree

check box 4-year college graduate

check box More than 4-year college degree

1. How well do you speak English?

check box Very well

check box Well

check box Not well

check box Not at all

1. Do you speak a language other than English at home?

check box Yes

check box No Arrow pointing to the right **If No, go to 54**

1. What is the language you speak at home?

check box Spanish

check box Chinese

check box Korean

check box Russian

check box Vietnamese

check box Some other language

1. Because of a health or physical problem, are you unable to do or have any difficulty doing the following activities? *(Please mark one response for each activity.)*

| Activity | I am unable to do this activity | Yes, I have difficulty | No, I do not have difficulty |
| --- | --- | --- | --- |
| 1. Bathing | check box | check box | check box |
| 1. Dressing | check box | check box | check box |
| 1. Eating | check box | check box | check box |
| 1. Getting in or out of chairs | check box | check box | check box |
| 1. Walking | check box | check box | check box |
| 1. Using the toilet | check box | check box | check box |

1. Do you ever use the internet at home?

check box Yes

check box No

1. Are you of Hispanic, Latino, or Spanish origin?

check box Yes, Hispanic, Latino, or Spanish

check box No, not Hispanic, Latino, or Spanish Arrow pointing to the right **If No, go to 58**

Which group best describes you?

check box Mexican, Mexican American, Chicano

check box Puerto Rican

check box Cuban

check box Another Hispanic, Latino, or Spanish origin

1. What is your race? Mark one or more.

American Indian or Alaska Native



Asian – Please Specify Arrow pointing to the right



check box Asian Indian

check box Chinese

check box Filipino

check box Japanese

check box Korean

check box Vietnamese

check box Other Asian

Black or African American



Native Hawaiian or Pacific Islander – Please Specify Arrow pointing to the right



check box Guamanian or Chamorro

check box Native Hawaiian

check box Samoan

check box Other Pacific Islander

check box White

1. Did someone help you complete this survey?

check box Yes

check box No Arrow pointing to the right **Thank you. Please return the completed survey in the postage-paid envelope.**

1. How did that person help you? Mark one or more.

check box Read the questions to me

check box Wrote down the answers I gave

check box Answered the questions for me

check box Translated the questions into my language

check box Helped in some other way

**Thank you. Please return the completed survey in the postage-paid envelope.**

*If you no longer have the envelope, you can mail your survey to:*

Medicare Provider Experience Survey  
[INSERT VENDOR ADDRESS]