FAX or Mail Return Form

Medical Provider Component

MEDICAL EXPENDITURE PANEL SURVEY

HOSPITAL

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Cover Sheet Plus _____ Page(s)

TO: Data Collection Specialist

FAX NUMBER: [FILL 1-800-XXX-XXXX] PHONE NUMBER: [FILL 1-800-XXX-XXXX].

FROM _____

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DATE _____

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OFFICE USE ONLY

Provider Name: [FILL PROVIDER NAME]

Case ID and Wave: [FILL ID AND WAVE NUMBER]

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Please send to:

MEPS-Medical Provider Component Director
One North Commerce Center
5265 Capital Boulevard
Raleigh, NC 27616

REFERENCE:
[FILL PROVIDER NAME]
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