

Medical Provider Component

M E D I C A L E X P E N D I T U R E P A N E L S U R V E Y

HOME CARE

Cover Sheet Plus [FILL NUMBER] Page(s)

TO: [FILL POC CONTACT NAME]

PROVIDER: [FILL PROVIDER NAME]

FAX NUMBER: [FILL FAX NUMBER]

DATE: [FILL CURRENT DATE]

FROM: [FILL DCS NAME]

PHONE NUMBER: [FILL 800-XXX-XXXX]

DIRECT LINE: [FILL DCS TELEPHONE NUMBER]

ITEMS SENT: [Letter]
[Authorization Form(s)]
[Fax or Mail Return Form]

[Announcement regarding change in contractors]
[Instructions and Confidential Client List]
[Brochure]

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Raleigh, NC 27616

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