FAX or Mail Return Form

Medical Provider Component

MEDICAL EXPENDITURE PANEL SURVEY

HOME CARE

If faxing material, please use this as your cover sheet.

Cover Sheet Plus _____ Page(s)

TO: Data Collection Specialist

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

FROM _____

_____

DATE _____

This fax includes confidential information, and may be used only by the person or entity to which it is addressed. If the receiver of this fax is not the intended recipient or his or her authorized agent, the receiver is hereby notified that dissemination, distribution or copying of this fax is prohibited. If you have received this fax in error, please notify the sender by calling [FILL 1-800-XXX-XXXX] and destroy the contents of this fax immediately. Thank you.

If mailing material, please include this cover sheet in your envelope. Please remember to include the confidential client worksheet. Thank you.

Please send to:

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

REFERENCE:
[FILL PROVIDER NAME]
[FILL PROJECT CHARGE NUMBER]

Provider Name: [FILL PROVIDER NAME]

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