FAX or Mail Return Form

Medical Provider Component

MEDICAL EXPENDITURE PANEL SURVEY

OFFICE-BASED

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 _____

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

OFFICE USE ONLY

Provider Name: [FILL PROVIDER NAME]

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

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]