

FAX or Mail Return Form

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

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]



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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]
[FILL PROJECT CHARGE NUMBER]