

Medical Provider Component

MEDICAL EXPENDITURE PANEL SURVEY

HOSPITAL

Cover Sheet Plus [FILL NUMBER] Page(s)

TO: [FILL POC CONTACT NAME]

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FAX NUMBER: [FILL FAX NUMBER]

DATE: [FILL CURRENT DATE]

FROM: [FILL DCS NAME]

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

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

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