

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

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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 Patient List]

[Brochure]

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