

# 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

**HOSPITAL**

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]**