Medical Provider Component

MEDICAL EXPENDITURE PANEL SURVEY

HOSPITAL

Cover Sheet Plus [FILL NUMBER] Page(s)

TO: [FILL POC CONTACT NAME]

PROVIDER: [FILL PROVIDER NAME]

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] [Announcement regarding change in contractors]
[Authorization Form(s)] [Instructions and Confidential Patient List]
[Fax or Mail Return Form] [Brochure]

Record File Number: [FILL NUMBER] Account File Number: [FILL NUMBER]

If faxing material, please fax to:
[FILL 1-800-XXX-XXXX]

If mailing material, please send to:
MEPS-Medical Provider Component Director
One North Commerce Center
5265 Capital Boulevard
Raleigh, NC 27616

Thank you for participating in this important study!

If you do not receive all pages or transmission is unclear, please call [FILL 800-XXX-XXXX].

For additional information log on to **http://www.MEPS.AHRQ.gov**.