Medical Provider Component





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]

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