

# 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



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]  
[Authorization Form(s)]  
[Fax or Mail Return Form]

[Announcement regarding change in contractors]  
[Instructions and Confidential Customer List]  
[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>.



This fax includes confidential information, and may be used only by the person or entity to which it is addressed. If the receiver of this fax is not the intended recipient or his or her authorized agent, the receiver is hereby notified that dissemination, distribution or copying of this fax is prohibited. If you have received this fax in error, please notify the sender by calling [FILL 1-800-XXX-XXXX] and destroy the contents of this fax immediately. Thank you.