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**FAX COVER SHEET (FOR MEDICAL REVIEW ONLY)**

TODAY'S DATE: \_\_\_\_\_

TO: \_\_\_\_\_

PROVIDER'S NAME: \_\_\_\_\_

YOUR NAME: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

COMPANY FAX: \_\_\_\_\_

PAGES INCLUDING THIS COVER SHEET: \_\_\_\_\_

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**PLEASE COMPLETE EACH SECTION TO ENSURE YOUR  
DOCUMENT WILL BE ROUTED CORRECTLY**

FOLDER SYSTEM: MEMBER ID# \_\_\_\_\_ - \_\_\_\_\_  
(MUST INCLUDE MEMBER SUFFIX)

DATE OF SERVICE: \_\_\_\_\_

DOCUMENT TYPE (XX) MEDICAL RECORDS

DOCUMENT DESCRIPTION (*PLEASE INDICATE ONE OF THE FOLLOWING...*)

<input type="checkbox"/>	ER TREATMENT	<input type="checkbox"/>	HEARING AID DOCUMENTATION
<input type="checkbox"/>	OFFICE/CLINICAL NOTES	<input type="checkbox"/>	IV HOME INFUSION
<input type="checkbox"/>	OPERATIVE REPORT	<input type="checkbox"/>	THERAPY NOTES (PT, OT, ST)
<input type="checkbox"/>	PHYSICIAN ORDERS	<input type="checkbox"/>	X-RAY INTERPRETATION REPORT
<input type="checkbox"/>	MANUFACTURES INVOICE	<input type="checkbox"/>	LAB REPORT
<input type="checkbox"/>		<input type="checkbox"/>	

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