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FAX COVER SHEET TO SUPPORT ELECTRONIC CLAIM SUBMISSION (FOR MEDICAL REVIEW ONLY)

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To: ____

Provider's Name: ____

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

	ER TREATMENT		HEARING AID DOCUMENTATION
	OFFICE/CLINCAL NOTES		IV HOME INFUSION
	OPERATIVE REPORT		THERAPY NOTES (PT, OT, ST)
	PHYSICIAN ORDERS		X-RAY INTERPRETATION REPORT
	MANUFACTURER'S INVOICE		LAB REPORT
	DENTAL DOCUMENTATION		

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