Fax: 740.699.6163

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

Today’s Date: ____________________
To: _______________________________________________________________________________
Provider’s Name: _________________________________________________________________
Your Name: ______________________________________________________________________
Phone Number: ________________________ Company Fax: ___________________________
Pages Including This Cover Sheet: _______ Provider NPI#: ____________________________
__________________________________________________________________________________

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

Folder System: _______ (THP internal use) Member ID#: ______________________ - _____
(MUST INCLUDE MEMBER SUFFIX)
Date of Service: __________________________________________________________________
Document Type (XX) Medical Records

DOCUMENT DESCRIPTION (PLEASE INDICATE ONE OF THE FOLLOWING)

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