CareOregon PWK Fax/Mail Cover Sheet

Complete all fields and fax or mail the form to the applicable address/number provided at the bottom of the page. Complete **ONE (1)** Medicare Fax/Mail Cover Sheet for each electronic claim for which documentation is being submitted. **This form should not be submitted prior to filing the claim.**

ACN:		DCN:	
Last Name:		Medicare/Medicaid ID #:	
First Name:		Middle Initial:	
Date of Birth:	Date(s) of Service: From	Date(s) of Service: To	
Billing Provider:		NPI:	TIN:
Total Charges		Total Number of Documentation Pages (including cover sheet):	

Notes

Sender Information	
Name:	Fax #:
Company Name:	Phone #:

Fax Number: (503) 416-8115

Address: CareOregon
PO Box 40328
Portland, OR 97240