



## 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

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### Sender Information

Name:	Fax #:
Company Name:	Phone #:

**Fax Number:** (503) 416-8115

**Address:** CareOregon  
PO Box 40328  
Portland, OR 97240

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