Provider Reimbursement Information System for Medicaid

Provider Enrollment Supporting Document Submission Cover Sheet

Provider Identifier Type:		*
ID Number:		*
Document Type:		*
Document Name:		*
Contact Name:		*
Contact Phone Number:	- - * **Ext:**	

<u>INSTRUCTIONS (Instructions will not appear on the printed cover sheet):</u>

To complete this cover sheet, download this file and open in Adobe Reader 9.0 or higher.

To Print, please use ONLY the 'Print Cover Sheet' Button above.

<u>THIS COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR FAX/MAIL WITH ALL SUPPORTING DOCUMENTATION BEHIND THIS COVER SHEET.</u>

FAX to : (801) 536-0471

OR Mail to:
Bureau of Medicaid Operations
Provider Enrollment
PO Box 143106
Salt Lake City UT 84114-3106

Form: PE01.1.11