NOT FOR DISTRIBUTION

PROVIDER AGENCY NAME:

Medicald ID	Racip Last	Recin First	Recip Addr	Recip Apt. #	Recip Quad	Recip Zip5	Recip Plane	Service Type	DHCF Program Type	Name of Suspended	Contacted Incoming/New Provider?	Date Contacted	Bene Transfer?	Date of	Name of	Date	Date Servi
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