



5802 Benjamin Center Drive #105
Tampa, FL 33634

Telephone: 855-444-3747
Fax: 855-427-3747

FACSIMILE COVER SHEET

To:	Customer Service
Company:	eQSuite
Phone:	855-444-3747
Fax:	855-427-3747
From:	
Company:	
Phone:	
Date:	
Pages incl. coversheet:	

Please update the exhausted days for Medicaid HMO recipient:

Name: _____

Medicaid ID#: _____

For Fiscal Year: 20 _____

Attached:

- Exhaustion of Benefit Denial Letter
- EOP – Exhaustion of Benefit Denial

Please allow one business day for update.

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