# UCP REVIEW TEAM
## MassHealth
FAX Cover Sheet

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| **Sender's Phone No:** _____ | **DOB:** _____ |
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## 617-241-6005

**Place a checkmark ( ✓ ) in the appropriate space below identifying the attached verification(s).**

_____ **UCP Eligibility Review Form**

_____ **Income**

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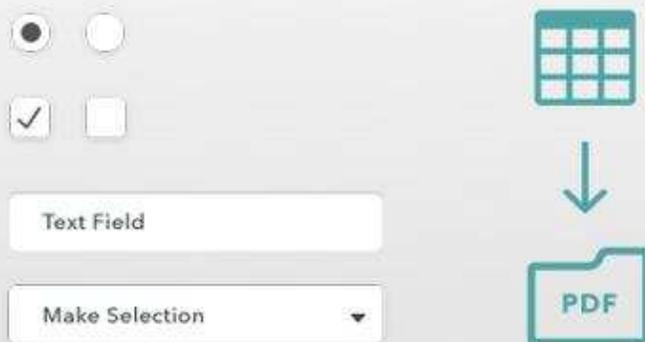## Powerful PDF Form Templates and Filling/Creating/Editing Function.

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