



**UCP REVIEW TEAM**  
**MassHealth**  
FAX Cover Sheet

**Facility Information**

Facility Name: \_\_\_\_\_

Sender's Phone No: \_\_\_\_\_

Sender's Name: \_\_\_\_\_

**Head of Household (HOH) Information**

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Soc. Sec. No: \_\_\_\_\_

Please include this cover sheet when faxing or mailing any documents to the MassHealth UCP Review Team.

**FAX NUMBER**

**617-241-6005**

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

\_\_\_\_ UCP Eligibility Review Form

\_\_\_\_ Income

\_\_\_\_ Other \_\_\_\_\_

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