

## PROVIDER SATISFACTION SURVEY

Dear Provider:

*Your input is very important to us! Please take a moment to complete the following survey along with any comments and return it to us by fax to:*

**FAX#: (212) 642-3480**

**Attention: Provider Relations**

**Or Mail To:**

**335 West 16<sup>th</sup> Street, 4<sup>th</sup> Floor**

**New York, NY 10011**

**Attn: Provider Relations Dept.**

Answer each statement by placing a check (✓) in the appropriate box. Please check the following: 5 = strongly agree 4 = agree 3 = neutral 2 = disagree 1 = strongly disagree