West Virginia Medicaid Standard Repayment Agreement for All Overpayment Notifications

Provider Name :
Provider NPI :
Case Number :
Principal Amount of Repayment : $

Please select which of the following options you wish to use to repay the above overpayment. Sign, date and return this form.

□ Check remittance for the full amount of the disallowance within 60 days of receipt of repayment date notification.

□ Placement of a lien against further Medicaid payments so that recovery is effectuated within 60 days after notification of the overpayment.

□ A repayment schedule over _____ months (not to exceed (12) months), through (select one method below):
□ Monthly check remittance or;
□ Monthly deductions from future claims**.**

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as an image transaction. **For inquiries, please call 1-866-243-9010**.

When information is used from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you will not receive your check back from your financial institution.

This form must be returned to: Bureau for Medical Services, Office of Program Integrity, 350 Capitol Street, Room 251, Charleston, West Virginia 25301-3710 no later than thirty (30) days after the date of this notification. If it is not returned, the Bureau for Medical Services will establish a lien against all future Medicaid payments until the overpayment is recovered in full and take any other necessary actions to assure recovery. **Checks should be made payable to the Bureau for Medical Services**.

_____ _____
Signature Date