Provider Name: _____ Overpayment Amount: $ _____

Provider NPI: _____ Amount Remitted: _____

Case Number: _____ Check Number: _____

Make checks payable to: **Bureau for Medical Services**

Please mail to: **Bureau for Medical Services**
Office of Program Integrity
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3710

edited 10/28/2024

ENSURE ACCURATE PROCESSING
PLEASE INCLUDE THE **CASE NUMBER** ON YOUR CHECK
AND ENCLOSE THIS VOUCHER WITH YOUR CHECK