THE WEST VIRGINIA MEDICAID SELF-REPORT FORM

THIS FORM SHOULD BE FILLED OUT AND SUBMITTED BY THE CLAIMANT OR THE CLAIMANT'S REPRESENTATIVE.

THIS FORM CONTAINS CONFIDENTIAL INFORMATION AND IS TO BE SUBMITTED ONLY TO THE ADDRESS, FAX NUMBER OR E-MAIL ADDRESS SPECIFIED BELOW. ANY OTHER USE OR DISTRIBUTION OF ALL OR PART OF THIS DOCUMENT IS PROHIBITED.

THE WEST VIRGINIA MEDICAID PROGRAM PROHIBITS PROVIDERS FROM BILLING MEDICAID RECIPIENTS FOR MEDICALLY NECESSARY SERVICES. THE PROVIDER MAY BILL THE RECIPIENT ONLY IF THE RECIPIENT SIGNS A WAIVER STATING THAT HE/SHE UNDERSTANDS THAT THE SERVICE IS NOT COVERED BY MEDICAID AND THAT HE/SHE WILL PAY FOR THE SERVICE. PLEASE REMEMBER, THE RECIPIENT MUST BE INFORMED BEFORE THE SERVICE IS PROVIDED.

PLEASE SEND SUBMISSIONS TO THE FOLLOWING ADDRESS:
BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA DEPARTMENT OF HEALTH
350 CAPITOL STREET, ROOM 251
CHARLESTON, WV 25301-3709
(304)558-1700

FAX NUMBER: (304)558-1325

PROVIDER NAME: _____ **CASE NUMBER:** _____

PROVIDER NUMBER: _____ **TIME PERIOD REVIEWED:** _____

COMPLETED BY: _____ **DATE COMPLETED:** _____

	Claim #	Date of Service	Amount	Medical Reason			Manual	Computer Generated	