THE WEST VIRGINIA MEDICAID SELF-REPORT FORM

THIS FORM MUST BE FILLED OUT AND RETURNED AT THE COMPLETION OF YOUR REVIEW.

THE INFORMATION FOR THIS FORM MUST BE ENTERED ON THIS EXCEL SPREADSHEET. HANDWRITTEN INFORMATION WILL NOT BE ACCEPTED.

DHHRBMSMedicaidOPI@wv.gov

PLEASE MAIL A REFUND TO THE FOLLOWING ADDRESS:
BUREAU FOR MEDICAL SERVICES
OFFICE OF PROGRAM INTEGRITY
350 CAPITOL STREET, ROOM 251
CHARLESTON, WV 25301-3710
(304) 558-1700

edited 02/26/2015

PROVIDER NAME: ____________________ CASE NUMBER: ____________________

PROVIDER NUMBER: ____________________ TIME PERIOD REVIEWED: ____________________

COMPLETED BY: ____________________ DATE COMPLETED: ____________________

Recipient Name	Medicaid ID	Date of Service	Procedure Code	Amount Billed	Amount Paid	Paid Date	Refund Amount	Transaction Control # (Claim #)	Reason for Error