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.
PLEASE E-MAIL THE COMPLETED FORM AS AN ENCRYPTED EXCEL SPREADSHEET, ALONG WITH THE STANDARD REPAYMENT PROVISION FORM AND ANY ADDITIONAL DOCUMENTATION TO:
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 10/20/2022

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

PROVIDER NPI: _____ **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

