Provider Name: Overpayment Amount: $________________________
Provider Number: Amount Remitted: $___________________________
Case Number: _____________ Check Number: ____________________

Make checks payable to: DHHR
Please mail to: Bureau for Medical Services
Office of Program Integrity
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3710
Revised 1-1-18

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