

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 08/01/2023

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