WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Inpatient Diagnostic Procedures

Case Name: _____
MA ID/Pending Medicaid No.: _____
Patient's Name: _____
Patient's Birthdate : _____
Patient's SSN: _____

Dear

We are requesting medical information on the above-named individual. At the request of Dr. _____, the Medical Review Team has approved _____ days hospitalization for the following diagnostic procedures
for this individual.

Charges for the above hospitalization should be made over the appropriate agency billing form with this letter attached and mailed to:

West Virginia Department of Health and Human Resources
Unisys
P.O. Box 3766
Charleston, West Virginia 25337

Payment will be made to Medicaid Providers only.

Sincerely yours,

WV DHHR Representative

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