



WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Report From Hospital Records

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

Dear Sirs,

We are requesting medical information for the above-named patient. This individual has informed us that he/she was a patient in your facility from _____ to _____ while under the care of Doctor _____.

Please send me a copy of your medical records for this individual. If there is any charge for this service, please bill on our hospital billing form, attach this letter, and mail 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,

Representative
WV Dept. of Health & Human Resources

