STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAL REVIEW TEAM (MRT)

INPATIENT DIAGNOSTIC PROCEDURES

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

Dear _____:

At the request of Dr. _____, the Medical Review Team has approved _____ days hospitalization for the following diagnostic procedure for this individual. We are requesting the results of the procedure(s) on the above-named patient.

Inpatient diagnostic procedure(s) and report requested by the Medical Review Team as follows: _____

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

West Virginia Department of Health and Human Resources
Unisys
Post Office Box 3766
Charleston, West Virginia 25337

Payment will be made to Medicaid **providers** only.

Sincerely yours,

DHHR Representative
(Worker fills in
County Office Address)