STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAL REVIEW TEAM (MRT)

PHYSICIAN'S HOSPITAL SERVICES

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

Dear Dr. _____:

The Medical Review Team has approved your request for _____ days hospitalization for _____ for the following diagnostic procedures _____

_____

When you obtain the results of these procedures, please mail a report of your findings to me.

Charges for the above hospital services you provided to this individual are to be made on the appropriate agency billing form with this letter attached and mailed to:

West Virginia Department of Health and Human Resources
Unisys
Post Office Box 3767
Charleston, West Virginia 25337

Thank you for your cooperation. Payment will be made to Medicaid **providers** only.

Sincerely yours,

DHHR Representative
(Worker fills in
County Office Address)