STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
MEDICAL REVIEW TEAM (MRT)

MEDICAL INFORMATION / DIAGNOSTIC REQUEST

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

Dear

DHHR is requesting the following on the above-named patient.

❒ General physical examination **on the attached DFA-RT-5**

❒ Psychological evaluation and report

❒ Eye examination **on the attached DFA-B-13 and/or DFA-B-13a**

❒ Outpatient diagnostic procedure**(s)** and report requested by the Medical Review Team as follows:

_____

_____

_____ has an appointment with you for the procedure**(s)** checked above on _____.

Please mail the report to me. A copy of the results of the diagnostic procedures should also be mailed to Dr. _____.

Charges for **any of the above services must** be billed **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 3767
Charleston, West Virginia 25337

The billing **must only** be for the requested service**(s) marked above.** No payment will be made for any other services billed on the invoice. Payment will be made to Medicaid Providers only.

Sincerely yours,

DHHR Representative