



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAL REVIEW TEAM (MRT)

REPORT FROM HOSPITAL RECORDS

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 patient. This individual has informed us that he was a patient in your facility **from** _____ to _____.

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
Post Office Box 3767
Charleston, West Virginia 25337

Payment will be made to Medicaid providers only.

Sincerely yours,

DHHR Representative

**(Worker fills in
County Office Address)**