



WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAL INFORMATION REQUEST

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

Dear

We are requesting the following information on the above-named patient.

- ☐ General physical examination and report on enclosed form.
- ☐ Psychological evaluation and report.
- ☐ Eye examination and report on the enclosed form.
- ☐ Outpatient diagnostic procedures and report requested by examining physician and/or the Medical Review Team as follows:

_____ has an appointment with you for procedure 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 this service are to be billed over 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 is to be for the requested service only. No payment will be made for any other services billed on the invoice. Payment will be made to Medicaid Providers only.

Sincerely yours,

Representative
WV DHHR

