WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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

Dear Dr.

The Medical Review Team has approved your request for _____ days hospitalization of _____ 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 mail to:

West Virginia Department of Health and Human Resources
Unisys
P.O. Box 3767
Charleston, West Virginia 25337

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

Sincerely yours,

WV DHHR Representative

_____

_____

DFA-RT-11
(Physician's Hospital Services)
Rev. 7/04