Provider Name: _____ Overpayment Amount: $_____

Provider Number: _____ Amount Remitted: _____

Case Number: **XXXXXXXXXXX** Check Number: _____

Make checks payable to: **DHHR**

Please mail to: **Bureau for Medical Services**
Office of Program Integrity
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3710

edited 04/28/2014

INSURE ACCURATE PROCESSING
PLEASE INCLUDE THE **CASE NUMBER** ON YOUR CHECK
AND ENCLOSE THIS VOUCHER WITH YOUR CHECK