Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Overpayment Amount: $ \_\_\_\_\_\_\_\_\_\_

Provider NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount Remitted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Check Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Make checks payable to: **Bureau for Medical Services**

Please mail to: **Bureau for Medical Services**

 **Center for Program Integrity**

 **350 Capitol Street, Room 251**

 **Charleston, West Virginia 25301-3710**

edited 03/25/2024

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ENSURE ACCURATE PROCESSING

PLEASE INCLUDE THE **CASE NUMBER** ON YOUR CHECK

AND ENCLOSE THIS VOUCHER WITH YOUR CHECK