West Virginia Children's Health Insurance Program

(Please print or type.)
Member's (child) Name _____
Last First Middle

Identification Number _____ Member's Date of Birth ____/____/____

Home Address _____

_____

Phone Number _____ - _____ - _____ Policyholder's Sex ☐ Male ☐ Female

Nature of Illness or Injury _____

Was illness or injury related to accident? ☐ Yes ☐ No

If yes, complete the following:
Date of accident: _____
Location of accident: _____

Was another party at fault? ☐ Yes ☐ No
Was illness or injury any way work related? ☐ Yes ☐ No

I certify that the above is correct and that I am claiming benefits only for charges incurred by the patient named above. I further authorize the release of any medical information necessary to process this claim.

Signature of Policyholder's
Parent / Guardian / Representative _____ Date _____

Itemized bills must accompany this claim form. These bills must include the following information:

1) Name of child covered by WVCHIP
2) The WVCHIP Policyholder's identification number
3) The nature of the illness or injury
4) Date(s) of service
5) A complete description of each service
6) The amount charged for each service
7) Diagnosis and procedure codes for each illness, condition and procedure
8) The provider's name, address, and NPI number

Mail to:
Molina
P.O. Box 3732
Charleston, WV
25337

If you have any question, please call Molina Medicaid Solutions toll-free at 1-800-479-3310.