



West Virginia Children's Health Insurance Program

(Please print or type.)

Policyholder's (child) Name _____
Last First Middle

Identification Number _____ Policyholder'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 FEIN # (federal identification number)

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

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