



# West Virginia Children's Health Insurance Program *Medical Claim Form*

*(Please print or type.)*

Policyholder's (child's) 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 an 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 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:**  
Acordia National  
PO Box 2451  
Charleston, WV 25329-2451

***If you have any questions, please call Acordia National toll-free at 1-800-356-2392.***