# WEST VIRGINIA CODE: §9-5-11b

**§9-5-11b. Release of information.**

(a) All recipients of medical assistance under the Medicaid program are considered to have authorized all third parties, including, but not limited to, insurance companies and providers of medical care, to release to the department information needed by the department to secure or enforce its rights as assignee under this chapter.

(b) As a condition of doing business in the state, health insurers, including self-insured plans, group health plans as defined in §6074(a) of the Employee Retirement Income Security Act of 1974, service benefit plans, third-party administrators, managed care organizations, pharmacy benefit managers or other parties that are by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service are required to comply with the following:

(1) Upon the request of the Bureau for Medical Services, or its contractor, provide information to determine the period that the service recipients, their spouse or dependents may be or may have been covered by the health insurer, including the nature of the coverage that is or was provided by the health insurer, the name, address, date of birth, Social Security number, group number, identifying number of the plan, and effective and termination dates. The information shall be provided in a format suitable for electronic data matches, conducted under the direction of the department, no less than monthly or as prescribed by the secretary. The health insurer must respond within sixty working days after receipt of a written request for enrollment data from the department or its contractor;

(2) Accept the right of the Bureau for Medical Services of recovery and the assignment to the state of any right of an individual or other entity to payment from the party for an item or service for which payment has been made by the Bureau for Medical Services;

(3) Respond to any inquiry by the Bureau for Medical Services regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of the health care item or service; and

(4) Accept a claim submitted by the Bureau for Medical Services regardless of the date of submission of the claim, the type or format of the claim form, lack of preauthorization or the failure to present proper documentation at the point-of-sale that is the basis of the claim: *Provided*, That the claim is submitted by the Bureau for Medical Services within the three-year period beginning on the date on which the item or service was furnished and any action by the Bureau for Medical Services to enforce its right with respect to the claim is commenced within six years of the Bureau for Medical Services' submission of the claim.