MEDICAID AGED & DISABLED WAIVER PROGRAM
MEDICAL NECESSITY EVALUATION REQUEST (8/06)
Please return this form to West Virginia Medical Institute 3001 Chesterfield Place
Charleston, WV 25304 Fax: 304-346-8948 Toll-Free Fax: 800-293-3009
ENTIRE FORM MUST BE COMPLETED IN ORDER TO PROCESS

Please check one: _____Initial _____Reevaluation

APPLICANT/MEMBER INFORMATION:

Name: _____ Date of Birth: ___/___/___ SSN: ___/___/____

Address: _____ City: _____ State: _____ Zip: _____

Medicaid #: _____ Phone #: _____ County: _____

CHECK ONE IF APPLICABLE:_____ Guardian _____ Power of Attorney _____ Committee

Contact Person: _____ Phone #: _____
(if applicant/member has Alzheimer's or other dementia, a contact person must be listed) (if other than applicant/member)

_____ _____
Signature of Applicant/Member or Representative Date

Case Management Agency (for Reevaluations Only): _____ Phone:_____

Address: _____ Fax: _____

REFERRING PHYSICIAN'S INFORMATION: (This information may be shared with the applicant/member.
THIS INFORMATION MUST BE LEGIBLE OR REQUEST WILL NOT BE PROCESSED.)

Physician's Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient's Diagnosis(es): _____

_____

Other Pertinent Medical Conditions: _____

_____

CHECK IF PATIENT HAS: ☐ Alzheimer's ☐ Multi-Infarct ☐ Senile Dementia

☐ Related Conditions (please describe): _____
Is Patient Terminal? ☐ Yes ☐ No

_____ _____
Physician's Signature (M.D. or D.O. only; original required; valid for 60 days) Date