WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

PHYSICIAN'S SUMMARY

Patient's Name: ____________________________

Case Name: ______________________________

MA ID/Pending Medicaid Number:______________

We are requesting medical information on the above-named patient. Because you have examined the patient, we would like your opinion on the topics below.

Attach this form to copies of your medical records or to the General Medial Examination Report and return to the address on the accompanying letter. The accompanying letter also contains billing procedures.

You need only complete those sections marked with an "X" on the left side.

☐ Date of Last Patient Contact: ______________________________

☐ Diagnosis: ______________________________________
____

☐ Prognosis: ______________________________________
____

☐ Length of Time Incapacity/Disability is Expected to Last: ______________

☐ Employment Limitation:______________________________
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____
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☐ Is this individual's incapacity or disability such that it is necessary for someone to stay in the home with him on a substantially continuous basis? Yes ☐ No ☐

☐ Is this individual able to care for children under age six? Yes ☐ No ☐

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Doctor's Signature

DFA-RT-8a
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