

**Completed Form Must be mailed or faxed to:**

West Virginia Medical Institute - City Center East  
4700 MacCorkle Ave., SE, Suite 201  
Fax: 304-346-8948; Toll Free Fax: 800-293-3009

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**ALL AREAS MUST BE COMPLETE, NO BLANK AREAS, OR THIS FORM WILL BE RETURNED.**

Check blank at top of form for an **Initial evaluation** (for a new applicant) **or reevaluation** (for a current member).

**Enter Applicant/Member Information:** Complete all areas leaving NO Blanks, if not applicable enter N/A. The applicant/member must sign and date (if unable a Legal Representative must sign).

**Legal Representative, Guardian or Contact:** Area MUST be complete if the applicant/member has Alzheimer's, dementia or a related diagnosis, if not applicable enter N/A.

**Case Management Agency or Fiscal Employer Agent Information:** Only completed if this is a current member requesting reevaluation.

**Referring Physician:** The physician information on this request must be complete and legible, to be processed. The request must be signed by the Physician (***MD or DO only; original required***) ***Note: Only the doctor may complete and sign this section of the form. No PA, RNC or other medical provider. IT MUST BE A MD OR DO.***