

WEST VIRGINIA TRAUMATIC BRAIN INJURY (TBI) WAIVER

MEDICAL NECESSITY EVALUATION REQUEST FORM

Please check one: Initial Reevaluation

Applicant/Member Information			
First Name, MI, Last Name		Social Security Number	
Current Physical Address	Address _____ City _____ State _____ Zip: _____ County of Residence: _____ Currently inpatient: <input type="checkbox"/> yes <input type="checkbox"/> no If yes provide the following information: Type of facility: <input type="checkbox"/> Nursing facility <input type="checkbox"/> Rehabilitation facility <input type="checkbox"/> Inpatient hospital Phone #: _____ Fax: _____ Contact Person: _____		
Mailing Address			
Phone Number		Gender (circle one) Male or Female	Email (if applicable)
Date of Birth (MUST be 22 or older)		Medicaid # (if applicable)	
Medicare # (if applicable)		Other health insurance (if applicable)	
Legal Representative Information			
<input type="checkbox"/> Check here if applicant is his/her own representative	Relation to applicant (check one): <input type="checkbox"/> Legal guardian <input type="checkbox"/> Family Member? Yes or No <input type="checkbox"/> Medical Power of Attorney <input type="checkbox"/> Durable Power of Attorney <input type="checkbox"/> Healthcare Surrogate <input type="checkbox"/> Other, Please Explain: _____		
First Name, MI, Last Name		Phone Number	
Mailing Address			
Applicant/Member/Legal Representative Signature			
I certify that the above information is accurate and complete to the best of my knowledge. I understand the information provided in this document will be treated confidentially.			
Signature of Applicant/Member or Legal Representative		Date	
Case Management Agency (Reevaluations Only)			
Agency Name: _____ Case Manager: _____			
Mailing Address: _____ City: _____ State: _____ Zip: _____			
Phone #: _____ Fax #: _____			
Referring Physician Information			
Physician Name		Phone # and Fax#	
Mailing Address			
Client's Diagnoses: (Please list all and include type of TBI) Include ICD-9 Code(s)	_____ _____		
Functional deficits directly attributable to TBI. (Please check if assistance is needed)	<input type="checkbox"/> Eating <input type="checkbox"/> Dressing <input type="checkbox"/> Orientation <input type="checkbox"/> Wheeling <input type="checkbox"/> Communication <input type="checkbox"/> Bathing <input type="checkbox"/> Cont./bladder <input type="checkbox"/> Transferring <input type="checkbox"/> Vision <input type="checkbox"/> Grooming <input type="checkbox"/> Cont./bowel <input type="checkbox"/> Walking <input type="checkbox"/> Hearing		
I attest that the applicant's condition meets the entry level definition of TBI: a non-degenerative, non-congenital insult to the brain caused by an external force resulting in total or partial functional disability and/or psychosocial impairment.			
Signature of Physician (MD,DO, or Neuropsychologist)		Date (valid for 60 days)	
Form Submission			
Mail or fax completed form to APS Healthcare, Inc..-WV 100 Capitol Street, Suite 600, Charleston, WV 25301 Fax: 866-607-9903 Phone: 866-385-8920			
DO NOT WRITE BELOW THIS LINE			
Received by the Administrative Service Organization:			
Signature of ASO Representative Receiving Form		Date	