

**WEST VIRGINIA TBI WAIVER
REQUEST TO CONTINUE SERVICES**

Submit by fax (866-607-9903) or email to wvtbiwaiver@apshealthcare.com

Date request is submitted: _____
 Name of person submitting request: _____
 Provider Agency (Please Include location if applicable): _____
 Contact Information:
 Phone #/Ext. _____
 Email Address: _____

Program Participant Name: _____
 Program Participant APS ID#: _____
 Anchor Date: _____
 Enrollment Date: _____

<input type="checkbox"/> Eligibility extension request	Elig. Exp. Date: _____	# days requested for extension: _____
--	------------------------	---------------------------------------

Briefly describe the reason for the service continuation request

*Provider should include this form with the program participant's record for verification of any approvals

*UMC staff should include summary of approval in program participant's record

Approved – Date extension expires: _____
 Not Approved
 Requested Additional Documentation (see notes section for more information)
 Name of UMC staff reviewing request: _____ Email Address: _____

Notes