

**AGED AND DISABLED WAIVER PROGRAM
MEDICAL NECESSITY EVALUATION REQUEST**

Please return to
West Virginia Medical Institute 3001 Chesterfield Place, Charleston, WV 25304
Fax: 304-346-8948 Toll-Free Fax: 800-293-3009

Please check one: Initial Reevaluation

APPLICANT/MEMBER INFORMATION:

Name: _____ Date of Birth: ____/____/____ Sex (circle one): M F
SSN: _____ Medicaid #: _____ Medicare #: _____
Physical Address: _____ City: _____ State: _____ Zip: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ County of Residence: _____

Signature of Applicant/Member **Date**

LEGAL REPRESENTATIVE INFORMATION: (Required if applicant/member has Alzheimer's, dementia or a related diagnoses)

Name: _____ Phone #: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Relation to Applicant/Member (check one):
 Guardian Committee Power of Attorney Medical Power of Attorney Durable Power of Attorney
Other _____

Signature of Legal Representative **Date**

CASE MANAGEMENT AGENCY or FISCAL EMPLOYER AGENT INFORMATION: (Reevaluations Only)

Agency Name: _____ Case Manager/Resource Consultant: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ Fax #: _____

REFERRING PHYSICIAN'S INFORMATION: (This information may be shared with the applicant/member.)

THIS INFORMATION MUST BE LEGIBLE OR THE REQUEST WILL NOT BE PROCESSED.

Name (MD or DO only): _____ Phone #: _____ Fax #: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____

Only Physician (M.D. or D.O) may fill out information below:

Patient's Diagnoses: _____

Other Pertinent Medical Conditions: _____

Does the individual have Alzheimer's, multi-infarct, senile dementia or a related condition? (circle one) Yes No
Specify: _____

Is the patient terminal? (circle one) Yes No

Signature of Physician (MD or DO only; original required) **Date (valid for 60 days)**