West Virginia Department of HEALTH

West Virginia Department of Health
EPSDT/HealthCheck Program
Preventive Health Screen

Name: DOB: **Page 3**

Additional Documentation

Date: _____ ☐ Periodic Screen ☐ Interperiodic Screen

An encounter outside of the defined periodicity for this child

100% Enteral Foods ☐ Yes ☐ No

If enteral foods, attach registered dietitian evaluation, most recent history and physical exam (H&P), height and weight, swallowing evaluation and labs.

Official Use Only:

Medical Necessity Form

It is the responsibility of the ordering healthcare provider to complete this medical necessity form and provide adequate documentation or information of the plan of treatment. The healthcare provider then gives this information either to the patient or directly to the treatment provider. The treatment provider must be enrolled in West Virginia Medicaid.

A. Patient's Medical ID Number: _____

B.

ICD-10 Code(s)	Clinical Diagnosis

C.

Item or Service Prescription	Length of need (# of months)	Amt/Mo Requested

D. Clinical Indication(s) for Item(s)/Service(s) Requested:_____

_____

E. Provider Certification

I certify that I have examined the member as part of an EPSDT periodic or interperiodic screen and the services requested are part of the plan of care. They are reasonable, medically necessary, and cost effective, and are not convenience items for the member or any individual involved with the member's care. I certify that the member or his/her representative has been offered a choice of vendors.

_____ _____
Print Provider/Clinic Name *Provider Signature*

_____ _____
Medicaid ID Number *Date*