AGED AND DISABLED WAIVER FORMS INSTRUCTIONS

Form Name: Aged and Disabled Waiver (ADW) Medical Necessity Evaluation Request (MNER)
Purpose: To request a medical evaluation for initial application to the ADW.

Completed FORM for initial evaluations must be mailed or faxed to:

Acentra Health
1007 Bullitt Street, Suite 200
Charleston, WV 25301
Toll Free Fax: 866.212.5053

- **ALL AREAS MUST BE COMPLETE, NO BLANK AREAS, OR THIS FORM WILL BE RETURNED.**
- The applicant's/participant's physician, nurse practitioner or physician's assistant must sign this form for an initial application. (Signature is valid for 60 days.)
- Check blank at top of form for an Initial evaluation (for a new applicant).
- Enter Applicant/Participant Information: Complete all areas leaving NO Blanks, if not applicable enter N/A. The Applicant/Participant must sign and date (if unable a Legal Representative must sign).
- Legal Representative, Guardian or Contact Area: MUST be complete if the Applicant /Participant has Alzheimer's, dementia or a related diagnosis, if not applicable enter N/A.
- Referring Physician: The physician's information on this request must be complete and legible to be processed. The request must be signed by the Physician (MD or DO), Nurse Practitioner, or Physician's Assistant. Original signature is required. (Signature is valid for 60 days.)