WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

TBI WAIVER PROGRAM
ENROLLMENT REQUEST FORM

Please use this form to request Enrollment in the Medicaid TBI Waiver Program. Fax the completed form to KEPRO at 1.866.607.9903. This form will only be accepted via fax.

Once the program participant has been enrolled you will be faxed an Enrollment Confirmation Notice.

There will be no Medicaid reimbursement for services provided before the date of the Enrollment Confirmation Notice.

Name: _____

Date: __/__/____ Date of Birth: __/__/____

Address: _____

County: _____

Medicaid Number: __ __ __ __ __ __ __ __ __ __ __

(Note: There are 11 digits in a Medicaid Number)

I, _____ ,confirm that _____ is at least
(Print Case Manager's Name) (Print Participant's Name)

3 years of age, a permanent resident of West Virginia, medically and financially eligible for the Program and has chosen to participate in the Medicaid TBI Waiver Program as an alternative to Nursing Care Facility. Documentation verifying this is maintained in the program participant's file.

Case Manager Signature _____

CM Agency Name _____

CM Agency Fax Number _____

***Note – The Case Management Agency and the Personal Attendant Services Agency is responsible for maintaining a copy of this request form, the fax confirmation that verifies the date/time you faxed the request and the Enrollment Confirmation Notice sent from KEPRO when the participant has been enrolled. These are kept in the program participant's file.**