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

Traumatic Brain Injury Waiver Services
Prior Authorization Cover Sheet

Agency Name: _____

Agency Address: _____

NPI# _____

Case Manager: _____

Telephone Number: _____ Fax Number: _____

Member's Name: _____

Medicaid Number: _____

Date of Birth ____/____/____

ICD-10 Code(s) _____

Submission Date ____/____/_____

	Total Units Requesting per month	Service Period for this request	Total Number of Units for Service Period
Personal Attendant Services **Traditional Model S5125 UB** **Personal Options Model S5125 UC**		**From:** **To:**	
Non-Medical Transportation **Traditional Model A0160 UB** **Personal Options Model A0160 U2**		**From:** **To:**	
Personal Emergency Response Unit **Traditional Model S5161 U5** **Personal Options Model S5161 U5 UK**		**From:** **To:**	
Case Management **G9002 U2**		**From:** **To:**	

Submit request through ANG provider portal: https://portal.kepro.com/

NOTE: Please attach the information listed below in the Member's UM request Case in ANG. Incomplete submission will be pended.

I. A copy of this cover sheet;
II. A copy of signed Person-Centered Service Plan;
III. A copy of the Person-Centered Assessment.
IV. A copy of the Person-Centered Discovery Tools
V. A copy of the budget; and
VI. Any other information that you feel will help justify your request.