WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

WEST VIRGINIA TRAUMATIC BRAIN INJURY (TBI) WAIVER

MEDICAL NECESSITY EVALUATION REQUEST (MNER) FORM

Demographic Information			
First Name, MI, Last Name		Social Security Number	
Currently Inpatient: ☐Yes ☐No	If yes, Name of Facility: _____ Contact Person:_____ Address: _____City:_____State:____ Zip:_____ Phone #: _____ Fax #:_____ **Type of facility:** ☐Nursing Facility ☐Rehabilitation Facility ☐Inpatient Hospital		
Home Mailing Address:	County of Residence: _____ Address_____ City_____ State_____Zip:_____		
Home Phone Number:		Gender (circle one) Male ☐ Female ☐	Email (if applicable)
Date of Birth **(MUST be 3 or older)**		Medicaid # (if applicable)	
Medicare # (if applicable)		Other health insurance (if applicable)	

Legal Representative Information			
☐**Check here if applicant is his/her own representative**	Relation to applicant (check one): ☐Legal guardian Family Member? ☐Yes ☐No ☐Medical Power of Attorney ☐ Durable Power of Attorney ☐Healthcare Surrogate ☐Other, Please Explain: _____		
First Name, MI, Last Name:		Phone Number:	
Mailing Address:			

Applicant/ Legal Representative Signature

I certify that the above information is accurate and complete to the best of my knowledge. I understand the information provided in this document will be treated confidentially.

_____ _____

Signature of Applicant or Legal Representative Date

Referring Physician/Practitioner Information (Please Print)			
Physician/Practitioner	Name	Phone #	Fax #
Mailing Address			
Client's Diagnoses: (Please list all and include type of TBI) **Include current ICD-Code(s)**	_____ _____		
Functional deficits directly attributable to TBI:	**(Please check if assistance is needed):** ☐ Eating ☐ Dressing ☐Orientation ☐Wheeling ☐Communication ☐ Bathing ☐ Cont./Bladder ☐ Transferring ☐Vision ☐ Grooming ☐Cont./Bowel ☐ Walking ☐ Hearing		

I attest that the individual's condition meets the entry level definition of TBI: A non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment or injury or anoxia due to near drowning.

_____ _____

Signature of Physician/Practitioner (MD, DO, PA-C, APRN or Neuropsychologist) Date (Valid for 60 days)

Form Submission

Mail or fax completed form to
Acentra Health 1007 Bullitt Street, Suite 200, Charleston, WV 25301
Fax: 866-607-9903 | Phone: 866-385-8920

DO NOT WRITE BELOW THIS LINE

Received by the Utilization Management Contractor (UMC):

_____

Signature of UMC Representative Receiving Form Date