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

WEST VIRGINIA TRAUMATIC BRAIN INJURY (TBI) WAIVER
MEDICAL NECESSITY EVALUATION REQUEST (MNER) FORM
Please check one: _____ Initial _____Reevaluation

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 or 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/program participant 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/current TBIW Participant /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/Recipient or Legal Representative Date

Case Management Agency (Reevaluations Only)

Agency Name:_____ Case Manager:_____
Mailing Address: _____ City:_____ State:____ Zip:_____
Phone #:_____Fax #_____

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 of 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
KEPRO 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