WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

TRAUMATIC BRAIN INJURY WAIVER PROGRAM
REQUEST FOR DISCONTINUATION OF SERVICE

Date: ___/___/_____

SUBMIT ALL REQUESTS TO:

Mail: Acentra Health
1007 Bullitt Street, Suite 200
Charleston, WV 25301

Fax: 866.607.9903

Member Information:

Name _____

Legal Representative if applicable _____

Address _____

Medicaid Number _____ Phone (___) ___ ___-___ ___ ___ ___

REASON FOR REQUEST:

☐ No Services have been provided for 180 continuous days.
Date of last service ___/___/_____ (required)

☐ Unsafe Environment: must attach documentation to support request for closure.

☐ Member is persistently non-compliance with service plan

☐ Member No Longer Desires Services: must attach a signed written request completed by the member and/or legal representative.

Requesting Entity _____

Address _____

Mailing Address _____

Phone (___) ___ ___-___ ___ ___ ___ Fax (___) ___-___

_____
Printed Name of Person Making Request

_____ _____ _____
Signature of Person Making Request Title Date

Note: If the request is approved by Acentra Health a notification of discontinuation of services will be mailed to the member (or legal representative) and a copy to the service providers.