AGED AND DISABLED WAIVER PROGRAM
MEDICAL NECESSITY EVALUATION REQUEST

ALL INFORMATION MUST BE LEGIBLE, OR THE REQUEST CANNOT BE PROCESSED

Type of Request: ☐ Initial. Submit to: KEPRO-ADW|1007 Bullitt Street, Suite 200, Charleston, WV 25301, FAX: 866-212-5053

☐ **Reevaluation**. Send completed form to Case Manager: FAX:

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|---|---|---|
| APPLICANT/PARTICIPANT INFORMATION | | |
| Legal Full Name: | Date of Birth: | Sex: ☐ M ☐ F |
| SSN #: | Medicaid #: | Medicare #: |
| Physical Address: | | |
| Mailing Address: | | |
| Phone #: | County of Residence: | |
| **Signature of Applicant/Participant** | **X** | Date: |
| CONTACT INFORMATION (REQUIRED IF APPLICANT/PARTICIPANT HAS ALZHEIMER'S, DEMENTIA OR RELATED DIAGNOSES) - **ALL APPLICANTS ARE ENCOURAGED TO LIST A CONTACT PERSON** | | |
| Name: | Phone #: | |
| Mailing Address: | | |
| Relationship to Applicant/Participant: (Choose ONLY ONE type of relationship) | ☐ Guardian ☐ Committee ☐ Power of Attorney ☐ Medical Power of Attorney ☐ Durable Power of Attorney ☐ Contact Person | |
| **Signature of Legal Representative (not needed if contact person)** | **X** | Date: |
| CASE MANAGEMENT AGENCY OR FISCAL EMPLOYER AGENT INFORMATION (Reevaluation Only) | | |
| Agency Name: | Phone #: | Fax #: |
| Case Manager/Resource Consultant: | | |
| Mailing Address: | | |
| REFERRING PHYSICIAN'S INFORMATION (This information may be shared with the applicant/participant). | | |
| Name: (MD, DO, PA, Nurse Practitioner) | Phone #: | Fax #: |
| Mailing Address: | | |

| **Patient Diagnoses and other Pertinent Medical Conditions:** | **ICD-10 codes:** |
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Is the patient terminal? ☐ Yes ☐ No

Does the patient have Alzheimer's, brain multi-infarct, senile dementia or a related condition?

☐ Yes ☐ No If "Yes," please specify:

| | | |
|---|---|---|
| **Signature of Physician (MD, DO, PA or Nurse Practitioner; original required)** | **X** | Date (valid for 60 days): |

Effective 7/13/18