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

Traumatic Brain Injury Waiver Services
Prior Authorization Cover Sheet

Agency Name: _____

Agency Address: _____

Agency NPI# _____

Case Manager: _____

Telephone Number: _____ Fax Number: _____

Member's Name: _____

Medicaid Number: _____

Date of Birth ____/____/____

ICD-10 Code(s) _____

TBI Waiver Covered Services	Total Units Requesting per month	Service Period for this request	Total Number of Units for Service Period
Personal Attendant Services **Traditional ModelS5125 UB** **Personal Options Model S5125 UC**		**From:** **To:**	
Non-Medical Transportation **Traditional ModelA0160 UB** **Personal Options Model A0160 U2**		**From:** **To:**	
Personal Emergency Response Unit **Traditional Model S5161 U5** **Personal Options Model S5161 U5 UK**		**From:** **To:**	
Environmental Accessibility Adaptions-Home **Traditional Model S5165 U2** **Personal Options Model S5165 U3**		**From:** **To:**	
Environmental Accessibility Adaptions-Vehicle **Traditional Model T2039 U2** **Personal Options Model T2039 U3**		**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. Prior Authorization Cover sheet;
II. Signed Person-Centered Assessment
III. Signed Person-Centered Service Plan

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IV. Person-Centered Discovery Tools
V. Member Controlled Assessment (If applicable)
VI. COI Exception Form (if applicable)
VII. A copy of the budget; and
VIII. Any other information that you feel will help justify your request