



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: Acentra-ADW | 1007 Bullitt Street, Suite 200, Charleston, WV 25301, FAX: 866-212-5053
 Re-evaluation. Send completed form to Case Manager: FAX:

APPLICANT/PARTICIPANT INFORMATION		
Legal Full Name:	Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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 <u>ONLY ONE</u> type of relationship)	<input type="checkbox"/> Guardian <input type="checkbox"/> Committee <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Medical Power of Attorney <input type="checkbox"/> Durable Power of Attorney <input type="checkbox"/> 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:
Is the patient terminal? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does the patient have Alzheimer's, brain multi-infarct, senile dementia or a related condition?		
<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please specify:		
Signature of Physician (MD, DO, PA or Nurse Practitioner; original required)	X	Date (valid for 60 days):