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

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:**

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):