

**AGED AND DISABLED WAIVER PROGRAM  
MEDICAL NECESSITY EVALUATION REQUEST**

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

**Type of Request** (please check one):  Initial       Reevaluation (scan and submit in CareConnection®)

**Submit Initial MNERS to:** KEPRO-ADW | 100 Capitol Street, Suite 600 | Charleston, WV 25301 | FAX: 866-212-5053

APPLICANT/PARTICIPANT INFORMATION			
Name:	Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
SSN #:	Medicaid #:	Medicare #:	
Physical Address:			
Mailing Address:			
Phone #:		County of Residence:	
<b>Signature of Applicant/Participant</b>	<b>X</b>	Date:	
LEGAL REPRESENTATIVE, GUARDIAN, OR 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	<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		
<b>Signature of Legal Representative (not needed if contact person)</b>	<b>X</b>	Date:	
CASE MANAGEMENT AGENCY OR FISCAL EMPLOYER AGENT INFORMATION (Reevaluation Only)			
Agency Name:		Case Manager/Resource Consultant:	
Mailing Address (include city, state, zip):			
Phone #:		Fax #:	
REFERRING PHYSICIAN'S INFORMATION (This information may be shared with the applicant/participant).			
Name (MD, DO, PA, Nurse Practitioner)		Phone #	Fax #
Mailing Address (include city, state, zip):			
Patient Diagnoses and ICD-10 codes	<hr/> <hr/>		
Other Pertinent Medical Conditions:			
Does the individual have Alzheimer's, brain multi-infarct, senile dementia or a related condition?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please specify
Is the patient terminal?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Signature of Physician (MD, DO, PA or Nurse Practitioner; original required)</b>	<b>X</b>	Date (valid for 60 days):	

