# WV **PERSONAL CARE** PROGRAM
## MEDICAL NECESSITY EVALUATION REQUEST (PC-MNER)

West Virginia Department of Health & Human Resources, BUREAU FOR MEDICAL SERVICES

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

<u>Type of Request</u> (please check one):  ☐ Initial   ☐ Reevaluation   ☐ Emergency/Facility Discharge

<u>Submit Initial and Emergency PCMNERs to</u> KEPRO-PC|1007 Bullitt Street, Suite 200 |Charleston, WV 25301 | FAX-844-794-6729

<u>Physicians, submit Reevaluation PC-MNERs</u> to the Personal Care Agency at Fax: _____

| APPLICANT/MEMBER INFORMATION | | | |
|---|---|---|---|
| First Name: | Middle Name: | Last Name: | Suffix: |
| Date of Birth: | Gender: <br> ☐ MALE   ☐ FEMALE | Is the person in a Specialized Family Care Home? ☐YES   ☐NO | |
| SSN: | Medicaid #: | Medicare # | **Dual Services?** ☐YES   ☐NO <br> **If yes, select Type of Waiver:** <br> ☐IDDW ☐ TBIW ☐ADW |

| |
|---|
| Member's Physical Address (Indicate Facility's name and contact info if the request is for Emergency/Facility Discharge): |
| Member's Mailing Address: |

| County of Residence (or Facility's County) | Member's Phone # (or Facility's Phone #): |
|---|---|

| Signature of Applicant/Member | X | Date: |
|---|---|---|

☐ Check if Applicant/Member is his/her own Legal Representative

**LEGAL REPRESENTATIVE, GUARDIAN, OR CONTACT INFORMATION (REQUIRED IF APPLICANT/MEMBER HAS ALZHEIMER'S, DEMENTIA OR RELATED DIAGNOSES <u>OR IS UNDER THE AGE OF 18</u>– ALL ARE ENCOURAGED TO LIST A CONTACT PERSON TO ASSIST**

| Name: | Phone #: |
|---|---|
| Mailing Address: | |

| Relationship to Applicant/Member | ☐ Guardian   ☐ Committee   ☐ Power of Attorney <br> ☐ Medical Power of Attorney   ☐ Durable Power of Attorney <br> ☐ Contact/Other (describe): _____ |
|---|---|

| Signature of Legal Representative (not needed if contact person) | X | Date: |
|---|---|---|

**REFERRING PHYSICIAN'S INFORMATION (This information may be shared with the applicant/member).**

| Name (MD, DO, PA, Nurse Practitioner) | | Phone # | Fax # |
|---|---|---|---|
| Mailing Address (include city, state, zip): | | | |
| Patient Diagnoses | | | |
| Other Pertinent Medical Conditions: | | | |

| Does the individual have Alzheimer's, brain multi-infarct, senile dementia or a related condition? | ☐ Yes   ☐ No | If "Yes," please specify | |
|---|---|---|---|
| Is the patient terminal? | ☐ Yes   ☐ No | | |

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

Form Effective 4-11-18