



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

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

Type of Request (please check one): Initial Reevaluation Emergency/Facility Discharge

Submit Initial and Emergency PCMNERs to Acentra-PC 1007 Bullett St Suite 200 | Charleston, WV 25301 | FAX-844-794-6729

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

APPLICANT/MEMBER INFORMATION			
First Name:	Middle Name:	Last Name:	Suffix:
Date of Birth:	Gender: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	Is the person in a Specialized Family Care Home? <input type="checkbox"/> YES <input type="checkbox"/> NO	
SSN:	Medicaid #:	Medicare #	Dual Services? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, select Type of Waiver <input type="checkbox"/> IDW <input type="checkbox"/> TBIW <input type="checkbox"/> 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:
<input type="checkbox"/> 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 OR IS UNDER THE AGE OF 18-- ALL ARE ENCOURAGED TO LIST A CONTACT PERSON TO ASSIST			
Name:		Phone #:	
Mailing Address:			
Relationship to Applicant/Member	<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/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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please specify	
Is the patient terminal?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Signature of Physician (MD, DO PA or Nurse Practitioner; original required)	X		Date (valid for 60 days):