HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

# WAIVER REVIEW FORM

## SEND TO THIRD PARTY ASSESSOR (TPA)

| *AGENCY NAME AND ADDRESS* | *PATIENT INFORMATION* | | |
|---|---|---|---|
| *Name* | *Name* | | *Date of Birth* |
| *Provider Number* | *Sex* ☐*Male* ☐*male* | *Medicaid I.D. Number* | *Social Security Number* |
| *Address* | *Waiver Type* DD ☐ MF ☐ *Review Type* ☐*itial* *An*☐*ual* *6 Mo*☐*eview* *Revision*☐ | | |
| *City, State, Zip* | *Diagnosis (list primary first)* *1.* | *2.* | |
| *Attending Physician* | *3.* | *4.* | |

| REGIONAL OFFICE ☐NE ☐NW ☐SE ☐SW | TERM OF ISP From: To: | DD WAIVER ARA CATEGORY Code: Term From: To: |
|---|---|---|

| SERVICES REQUESTED | | | | SERVICES CERTIFIED (shaded area for UR USE ONLY) | | | | |
|---|---|---|---|---|---|---|---|---|
| 1 Type of Service | | Units Requested | Procedure Code/Modifiers | 1 Procedure Code/Modifier(s) | Units Approved | Start Date | End Date | |
| Begin Date | End Date | Provider Name/Provider Number | | Provider Signature/Date | | UR Number/Date | Prior Authorization Number | |
| 2 Type of Service | | Units Requested | Procedure Code/Modifiers | 2 Procedure Code/Modifier(s) | Units Approved | Start Date | End Date | |
| Begin Date | End Date | Provider Name/Provider Number | | Provider Signature/Date | | UR Number/Date | Prior Authorization Number | |
| 3 Type of Service | | Units Requested | Procedure Code/Modifiers | 3 Procedure Code/Modifier(s) | Units Approved | Start Date | End Date | |
| Begin Date | End Date | Provider Name/Provider Number | | Provider Signature/Date | | UR Number/Date | Prior Authorization Number | |
| 4 Type of Service | | Units Requested | Procedure Code/Modifiers | 4 Procedure Code/Modifier(s) | Units Approved | Start Date | End Date | |
| Begin Date | End Date | Provider Name/Provider Number | | Provider Signature/Date | | UR Number/Date | Prior Authorization Number | |
| 5 Type of Service | | Units Requested | Procedure Code/Modifiers | 5 Procedure Code/Modifier(s) | Units Approved | Start Date | End Date | |
| Begin Date | End Date | Provider Name/Provider Number | | Provider Signature/Date | | UR Number/Date | Prior Authorization Number | |

| Waiver Client Signature | Date | Parent/Guardian Signature | Date |
|---|---|---|---|
| | | | |

| Case Manager's Signature | Phone | Date | UR Physician/Review Coordinator | Date |
|---|---|---|---|---|
| | | | | |

Cc:
UR Agency
CM Agency
ISD Field Office
MCO