WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

PSYCHIATRIST'S SUMMARY

Patient's Name: _____

Case Name: _____

MA ID/Pending Medicaid Number:_____

Our Medical Review Team needs your help in making a fair decision as to whether or not the above-name patient meets our definition of incapacity or disability. Because you have examined the patient, we would like your opinion on the topics below.

Attach this form to copies of your medical records or to the General Medical Examination Report and return to the address on the accompanying letter. The accompanying letter also contains billing procedures.

You need only complete those sections marked with an "X" on the left side.

☐ Date of Last Patient Contact: _____

☐ Diagnosis: _____

_____

☐ Prognosis: _____

_____

☐ Length of Time Incapacity/Disability is Expected to Last: _____

☐ Employment Limitation:_____

_____

_____

_____

_____

☐ Is this individual's incapacity or disability such that it is necessary for someone to stay in the home with him on a substantially continuous basis? Yes ☐ No ☐

☐ Is this individual able to care for children under age six? Yes ☐ No ☐

_____

Psychiatrist's Signature