



STATE OF WEST VIRGINIA
 DEPARTMENT OF HEALTH AND HUMAN RESOURCES
MEDICAL REVIEW TEAM (MRT)

PSYCHIATRIST'S SUMMARY

Patient's Name: _____

Case Name: _____

MA ID/Pending Medicaid No.: _____

Dear Dr. _____:

The Medical Review Team is requesting your assistance in making a fair decision as to whether or not the above-named 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.

Complete only those sections that are marked or checked.

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

 Doctor's Signature