STATE OF WEST VIRGINIA

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAL REVIEW TEAM (MRT)

PHYSICIAN'S SUMMARY

Patient's Name: ____________________________

Case Name: ____________________________

MA ID/Pending Medicaid No.: ____________________

Dear Dr. ______________________________:

We are requesting medical information on the above-named patient. 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: ____________________________

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☐ Prognosis: ____________________________

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

☐ Employment Limitation: ____________________________

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☐ 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

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Doctor's Signature

DFA-RT-8a
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