WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

ADDITIONAL MEDICAL REQUEST

Date: _____

County: _____ _____

Client's Name: _____

Client's SSN: _____

Dear DHHR Worker _____

The medical and/or social information furnished on this case is not sufficient to enable the reviewing physician to determine whether disability or incapacity exists. The reviewing physician is requesting the following information before a decision can be made.

When submitting the above information, please attach this memo.

Sincerely yours,

Division of Family Assistance
Medical Review Team

DFA-RT-14
Rev. 5/05