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 ☐ Female	Medicaid I.D. Number	Social Security Number
Address	Waiver Type ☐ DD ☐ MF Review Type ☐ Initial ☐ Annual ☐ 6 Mo. Review ☐ 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

MAD 046 Revised 8/28/14