



Department of Health and Human Resources
Office of Maternal, Child and Family Health
Bureau for Public Health
WV BIRTH TO THREE

SERVICE AUTHORIZATION REQUEST FORM

Child's Name: _____ Date of Birth: _____

SC Name: _____ Date of Request: _____

SC Phone: _____ Email Address: _____

Assistive Technology Device (All requests must relate to an appropriate IFSP outcome, and meet the WV Birth To Three Service Definition for Assistive Technology)

List items individually. Attach the appropriate IFSP outcome page and AT Request Form with team signatures. Provide description/catalog information for EACH item requested. Include size and color, if applicable.

1. _____
2. _____
3. _____
4. _____
5. _____

Durable Medical Equipment Vendor (Preferred Durable Medical Equipment vendor in the child/family's geographical area)

DME Vendor Name: _____

Address: _____

Shipping Address (Provide name and address of where equipment will be shipped)

Name: _____

Physical Address: _____

Audiological Evaluation **Hearing Aid, Batteries and Ear Molds** **Other Hearing Aid Supplies**
Please List: _____

Company Name: _____ Audiologist Name: _____

Address: _____

Scheduled Appointment Date: _____

Sign Language/Bilingual Interpreter

Provider of Service: _____

Address: _____ Telephone: _____

This box is for state personnel only:

DENIAL Reason: _____

APPROVAL _____

PENDING Info Needed: _____

Signature: _____ Date: _____