KanCare Ombudsman Office
Phone: Toll Free: 1-855-643-8180
TTY: 771
Email: KanCare.Ombudsman@ks.gov
Website: www.kancare.ks.gov/kancare-ombudsman-office

Fee for Service Grievance Process

The ***Fee for Service Grievance*** process is for current KanCare members who do not have an MCO. These grievances are filed with the Kansas Medical Assistance Program or KMAP.

What is a Grievance? A grievance is an expression of dissatisfaction about any matter other than a *Notice of Adverse Benefit Determination* (previously called an Action). A Notice of Adverse Benefit Determination is when a state agency sends a notice regarding your eligibility or benefits (i.e. a state agency such as Kansas Medical Assistance Program/KMAP, Kansas Department of Health and Environment/KDHE, Kansas Department of Aging and Disability Services/KDADS or Kansas Department of Children and Families/DCF).

When would I file a Grievance? If you have a problem with Kansas Medical Assistance Program or a network provider's services concerning such things as customer service, access to care, or your rights and dignity, you may file **an official complaint, or grievance.**

Possible subjects or examples of a Fee for Service Grievance might be:

- You are unhappy with the quality of your care or services provided
- Poor behavior by an employee of KMAP or one their providers
- The failure to respect a member's rights and dignity
- Issues with transportation
- You received a bill from a provider that should be covered by KMAP and KMAP said they are not covering it.
- Did not receive culturally appropriate care (In this case, you may also file an additional, state agency grievance)

How do I file a Fee for Service Grievance?

- Write to the Kansas Medical Assistance Program (KMAP) about it; or
- Ask a representative of your choice to call or write to the KMAP.
  If you ask a representative to call or write to the KMAP, you will need to include written approval for them to represent you. You may choose from one of the following:
  - Authorized Representative Designation Form: for Appeals, Hearings and Grievances
  - Medical Representative Authorization: for persons on Medicaid to authorize (allow) another person to help them with medical calls, paperwork, etc. If the person assisting is a DPOA or Guardian, they must include that paperwork with this form. Read the form carefully for details.

KanCare Ombudsman Office
Phone: Toll Free: 1-855-643-8180
TTY: 771
Email: KanCare.Ombudsman@ks.gov
Website: www.kancare.ks.gov/kancare-ombudsman-office

To submit a Fee for Service Grievance, write to KDHE:

Mail to:

Kansas Medical Assistance Program
Medicaid Grievances

PO Box 3751
Topeka, KS 66601

What documentation do I need?

- You can file a grievance without providing documentation.
- If you have a record of when phone calls were made, who you talked to, general info regarding the conversation, that may be helpful

What is the timeline?

- There is no deadline for a submission of a grievance.
- The agency will resolve within 30 days of receipt of the grievance.

Fee for Service Grievance Worksheet

There is no special form required to submit an official grievance. You may use the following Grievance Worksheet as a script to guide you on the phone, in writing a letter, or you may mail or fax this worksheet as an alternative to a phone call or letter to submit your official Fee for Service Grievance**. This worksheet is an organizational tool only, and does not provide legal advice.**

KanCare Ombudsman Office
Phone: Toll Free: 1-855-643-8180
TTY: 771
Email: KanCare.Ombudsman@ks.gov
Website: www.kancare.ks.gov/kancare-ombudsman-office

Fee for Service Grievance Worksheet

I am submitting this Fee for Service Grievance to: _____

Applicant/Member Contact Information

KanCare Applicant/Member Name (Please Print) _____

Medicaid ID# or Case# _____

KanCare Applicant/Member Street Address or PO Box: _____ Apt #: _____

City _____ State _____ Zip Code _____

Preferred Phone: _____ Alternative Phone: _____

Grievance Description
There is no special form required to submit an official Fee for Service Grievance. However, the KanCare Ombudsman office suggests that you write out your story with a clear time line marking the specific event that occurred as well as any difficulties that occurred due to that event.

Description of the event for which you are submitting a grievance (If you need more room, attach additional pages.): _____

_____

_____

_____
Printed Name of Member (or parent/guardian) *

_____ Date: _____
Signature of Member (or parent/guardian) *

*Relationship to Member: __ Self __ Parent __Guardian __ POA

__ Other (explain): _____

*Note: If you are representing the KanCare applicant/member, please send this worksheet or your letter with one of the following two forms:

- Medical Representative Authorization form (See page 1 for links to the form)
- Authorized Representative Designation Form (See page 1 for links to the form)
- The Durable Power of Attorney (DPOA) information should also be attached if applicable.