



## 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).

Note: A Notice of Adverse Benefit Determination is when a state agency sends a notice that there has been an adverse decision/determination made 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). A grievance does NOT change an adverse benefit determination.

**When would I file a Grievance?** If you have a problem with Kansas Medical Assistance Program (KMAP) 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. Once the member has completed the grievance process, if unable to obtain culturally appropriate care, you can contact the KanCare Ombudsman's office for assistance.

### How do I file a Fee for Service Grievance?

- Call or 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.



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**To submit a Fee for Service Grievance, write to KMAP:**

**Mail to:**

Kansas Medical Assistance Program  
Medicaid Grievances

PO Box 3751  
Topeka, KS 66601

**Toll Free:** 1-800-766-9012

**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.

**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.**



## 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.