



P.O. Box 3599
Topeka, KS 66601-9738
Phone: 1-800-792-4884

STATEMENT OF MEDICAL NECESSITY

Consumer's Name: _____ Case Number: _____

Date of Birth: _____ Social Security Number: _____

What is the service or item(s) being prescribed?

What are the customary charges for this service or item(s)?

What is the medical reason for the service or items(s)? (Please be specific. Include information on other treatment options which have been unsuccessful.)

What is the quantity/frequency and for what duration is the service or item(s) needed?

Provider's Name: _____

Address: _____

Telephone Number: _____

Prescribing Practitioner's Signature

Date

If you have any questions, please call the KanCare Clearinghouse at 1-800-792-4884 between the hours of 8:00 am to 5:00 pm Monday through Friday.