FAX COMPLETE TO 785-296-4813 ATTN: KDHE/DHCF PHARMACY

DME Issue Inquiry Form

MCO (choose one)

- Amerigroup
- Sunflower
- United HealthCare

Provider Name:_____

Provider NPI:_____

Claim #_____

Rx#_____

Member Medicaid ID#_____

Date of Service:_____

NDC# (if applicable) _____

HCPCS/CPT code# (if applicable) _____

Problem:-

_____

_____

_____

Provider Contact Name:_____
Provider Contact Phone:_____
Provider Contact Email:_____
Provider Contact Address:_____
_____

RETURN COMPLETED FORMS:

1. Fax to: 785-296-4813 ATTN: KDHE/DHCF Pharmacy
2. Mail to:
   Pharmacy Program Manager
   Division of Health Care Finance
   Kansas Department of Health and Environment
   900 SW Jackson St., Suite 900-N
   Topeka, KS 66612
3. Return to your professional association representative
4. For general questions please contact Kelley Melton kmelton@kdheks.gov 785-296-8406 or Liane Larson llarson@kdheks.gov 785-296-0334. Please do not send PHI via unsecured email.