Kansas
Department of Health and Environment
Division of Health Care Finance

PO Box 3599
Topeka, KS 66601-9738

Your request for medical assistance is INCOMPLETE. You will be DENIED if the following information is not received by Due date.

We received the enclosed healthcare coverage application or review for you. We are returning the forms to you; it is unclear who signed the application or review. We cannot process your request without a valid signature.

If you are applying for yourself, please review the enclosed forms that we received. Make sure you agree with the information provided. If the information is not correct or is incomplete, make changes where needed. After you have reviewed the forms, read and sign the enclosed **M-6 Medicaid Application/Review Signature Page**.

If you wish to allow someone other than yourself to sign the application or review for you, you can name that person to be your medical representative. To name someone to be your medical representative, read, complete and sign the enclosed **Medical Representative Authorization Form**. That person will then be able to act for you. That person should review the enclosed application or review and then read and sign the enclosed **M-6 Medicaid Application/Review Signature Page**.

If you have a guardian or conservator, you cannot sign the application or review yourself or name someone to sign for you. Your guardian or conservator must sign the application or review for you. If you have a guardian or conservator, that person should review the enclosed application or review and then read and sign the enclosed **M-6 Medicaid Application/Review Signature Page**. Please also provide proof that this person is your guardian or conservator.

Please return the reviewed forms and the signed **M-6 Medicaid Application/Review Signature Page.** If you are naming a medical representative to act for you, return the completed and signed **Medical Representative Authorization Form**. If you have a guardian or conservator, please provide proof. You may return this information to us in the enclosed envelope. If this information is not provided your application/review will be denied.

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

ALL OF THE INFORMATION REQUESTED ABOVE MUST BE SENT TO: KanCare PO Box 3599 Topeka, KS 66601

Fax numbers: Family Medical 1-800-498-1255 or Elderly & Disabled 1-844-264-6285

We offer interpretation services at no cost. Ofrecemos servicios de interpretación sin costo alguno.

Si no puede leer este aviso en inglés, llame al 1-800-792-4884 y una persona del programa KanCare que hable español le ayudará.