Kansas
Department of Health and Environment
Division of Health Care Finance

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

MEDICAL ONSET DATE VERIFICATION

I. IDENTIFYING INFORMATION: To be completed by KDHE

Claimant's First Name: _____ Middle:_____ Last:_____

Social Security Number: _____ Date of Birth: _____ Case Number: _____

Address: _____

City: _____ State: ___ Zip: _____

II. REFERRAL INFORMATION: To be completed by KDHE

The applicant/recipient named above has recently applied or has been approved for SSI benefits with the SSI onset date established as _____ . In order to determine eligibility and claim Federal Financial Participation (FFP) on medical expenditures during the dates beginning _____ to _____ an earlier approximate medical onset date is necessary.

III. DISABILITY DETERMINATION INFORMATION: To Be Completed by DDS

Medical Onset Date: _____

Remarks:_____

_____

_____

_____

_____

_____

_____

_____ _____

Disability Determination Examiner's Signature Date