Kansas
Department of Health and Environment
Division of Health Care Finance

Medical RDB Request

* denotes required fields for form to be considered valid

*Case Number:						
*Primary Applicant's Name:						
*Action Requested:	Action Requested- Required field -Choose one					
Resource ID (if updating):						
Image Location	*Doc Type		*Rcvd date		*Page #	
	Doc Type		Rcvd date		Page #	

*Administrative Role	Administrative Role -Required field -Choose one		
Organization Name (if facilitator)			
*Person Name			
Phone Number		Type:	Choose one

*Mailing address					
*City		*State		*Zip	

Physical address					
City		State		Zip	

Current address in KEES to be updated					
City		State		Zip	
Phone Number				Type:	Choose one

Comments:
