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

Kansas Department of Health and Environment
Division of Health Care Finance

# Medical Review of Emergency Service

This form is used for establishing SOBRA eligibility and must be initiated by eligibility staff.
It is not required for labor and delivery services.

## I. Request for Information to be completed by KanCare Eligibility Staff

Claimant's First Name: Middle: Last:

Date of Birth: Medicaid ID: Case Number:

The above-named person has applied for medical assistance from the Kansas Department of Health and Environment, Division of Healthcare Finance. Information is needed to determine **if the medical services provided were for an emergency medical condition** after the sudden onset of a medical condition manifested by symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Is this a Redetermination request? ◯ No ◯ Yes

If yes, select a reason:

◯ Provider submitted new medical records after a technical denial.

◯ Provider submitted new medical records and requests specific dates (previously denied) to be reviewed.

KanCare Staff: Email:

## II. Verification of Emergency Services to be completed by provider

**In order to verify the emergent nature of the services, the following information must be provided for each visit. This form and medical records listed below must be mailed/faxed to**:

KanCare Clearinghouse, PO Box 3599 Topeka, KS 66601 or fax to 1-800-498-1255.

To ensure timely processing; this form and all documents must be submitted within 12 days from receipt of this form.

Payment for services may not be made without the following documentation:

**A.** For Hospital Services (Inpatient, Outpatient, ER)
1. History and Physical
2. Discharge Summary
3. Emergency Room Records with Doctor's Exam and Notes
4. Case Management Notes (required for stays longer than 15 days.)

**B.** For All other Outpatient Services (i.e., Physician, FQHC, RHC, etc.)
1. Exam Notes
2. History

Services meeting the above criteria were rendered on the following dates: _____ through _____.

_____ _____
Provider Name Provider Phone Number

_____
Provider Address

_____ _____
Provider's Signature (or Designee) Date

## III. Technical Review to be completed by Fiscal Agent Staff

☐ **Denied** ☐ **Send to SOBRA Manager (not denied)**

Denial Reasons (Mark as many below as applicable)

☐ Insufficient Medical Records ☐ Discrepant Information ☐ No Medical Records Provided

The following documents were not provided:

☐ History and Physical ☐ Emergency Room Records with Doctor's Exam and Notes

☐ Discharge Summary ☐ Case Management Notes

Notes:_____

_____

_____

_____

_____ _____

Fiscal Staff Signature Date

## IV. Medical Review to be completed by SOBRA Manager

☐ **Denied** ☐ **Approved** ☐ **Partial Approval**

Notes:_____

_____

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_____

_____

_____

_____ _____

SOBRA Manager Signature Date

Fiscal Staff and/or SOBRA Manager returns form to KanCare Clearinghouse for eligibility finalization once complete.