Request for Medicaid Hearing
Eligibility Hearing or Fee-For-Service Hearing
Kansas Office of Administrative Hearings

Date:_____

I am requesting a hearing before an impartial hearing officer regarding my Medicaid eligibility or Fee-For-Service Medicaid Services. I understand I may represent myself or use an attorney, relative, friend or other spokesperson.

Applicant/Beneficiary**:** _____ Phone: _____

Case #: _____ Date of Birth:_____

Address:_____

Representative (if applicable): _____ Phone: _____

Representative's Address:_____

Representatives should include their authorized representative form with this form.

Representative is (Check One):

☐ parent/relative; ☐ advocate/friend; ☐ attorney; ☐ provider; ☐ guardian; ☐ conservator;
☐ other (describe): _____

Date of Action Being Appealed: _____

Please attach a copy of the notice about which you are appealing. Explain why you are not satisfied with the decision and send copies of any papers you think may help explain the problem.

(**You will need to continue on page 2 if box above is full**)

You can ask for an expedited (fast) hearing if you have an urgent medical need. **You must send medical documents as proof of the urgent medical need at the time you ask for a fast hearing.** We will review these requests as quickly as possible. We will approve or deny the request based on the documents submitted at the time of the request. If we approve the request, your hearing will be scheduled as quickly as possible. If we deny the request, your hearing will be scheduled in the usual amount of time.

☐ I would like to request a fast hearing. **I am sending medical documents that prove I have an urgent medical need for a fast hearing.**

Name of Person Requesting Administrative Hearing

Name of Person Completing This Form
☐ Submitted Verbally ☐ Written

You may submit your hearing request by mail, fax, or by telephone:

Mail: Office of Administrative Hearings
1020 S. Kansas Ave.
Topeka, Kansas 66612

Fax: Office of Administrative Hearings_____1-785-296-4848
(Keep a copy of the page that shows your fax was successful.)

Telephone: KanCare Clearinghouse (Eligibility decisions)_____1-800-792-4884
KMAP Customer Service (Fee-for-service beneficiary service decisions)_____1-800-766-9012

This hearing request form can be found at https://www.kancare.ks.gov/consumers/state-fair-hearings

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*Additional Page for Continuation of Explanation Information: