Kansas Department of Health and Environment

P.O. Box 3599
Topeka, KS 66601-9738
Phone: 1-800-792-4884
Fax: 844-264-6285

KanCare

Medical Review of Emergency Services For Establishing SOBRA Eligibility

(Except Labor and Delivery)

I. REQUEST FOR INFORMATION (to be completed by KanCare staff)

Individual's Name: _____ _____ _____
(First) (Middle) (Last)

Birthdate: _____ Case Number: _____

Medicaid ID #:_____

The above-named person has applied for medical assistance from the KDHE- DHCF, and 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.

KanCare Case worker: _____

Date sent: _____

Phone: _____

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, this form attached to those records and the entire document mailed to:
Kansas Medical Assistance Program, Office of the Fiscal Agent, CC: 765L, SOBRA Staff, P.O. Box 3571, Topeka, KS 66601-3571.

This form is not required for routine labor and delivery services.

To ensure timely processing this form and all documents must be submitted to the fiscal agent within 30 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
2. Physical
3. Admission & Discharge Summary
4. Emergency Room Records with Doctor's Exam and Notes

B. For All Other Outpatient Service (i.e., Physician, FQHC, RHC, etc.)

1. Exam Notes
2. History

Services meeting the above criteria were rendered on the following date(s):
_____ through _____

Provider Name: _____

Provider number: _____

Address: _____

City: _____ State: _____ Zip code: _____

_____ _____

Provider's Signature (or Designee): _____

Date form completed: _____

III. MEDICAL REVIEW (to be completed by SOBRA Manager or Fiscal Agent Staff)

Decision:

_____

_____

_____

_____

_____

_____

Authorized Reviewer's Signature: _____

Date: _____

INSTRUCTIONS FOR MS-2156

Part I must be completed by KANCARE staff and forwarded to the appropriate provider for form completion and records request.

Part II must be completed by the appropriate provider, signed and attached to the records described within the section, then mailed to:

Kansas Medical Assistance Program
Office of the Fiscal Agent, CC: 765L
Attn: SOBRA staff
P. O. Box 3571
Topeka, Kansas 66601-3571

Part III must be completed by SOBRA Manager or designated Fiscal Agent staff and returned to KanCare Clearinghouse for eligibility finalization.