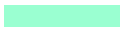




P.O. Box 3599  
Topeka, KS 66601-9738  
Phone: 1-800-792-4884  
Fax: 844-264-6285



### STATEMENT OF MEDICAL NECESSITY



|                                 |  |
|---------------------------------|--|
| Patient's Name                  |  |
| Social Security Number          |  |
| Date of birth                   |  |
| Spouse's Social Security Number |  |

•What is the service or item(s) being prescribed?

---

---

---

---

•What are the customary charges for this service or item(s)?

---

• What is the medical reason for the service or item(s)? Please be specific and include information on other treatment options which have been unsuccessful.

---

---

---

---

---

• What is the quantity/frequency and for what duration is the service or item(s) needed?

---

---

---

---

---

Provider's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

\_\_\_\_\_  
Prescribing Practitioner's Signature

\_\_\_\_\_  
Date

When form has been completed, fax or mail to:

**KanCare Clearinghouse**  
PO Box 3599  
Topeka, KS 66601

FAX: 1-844-264-6285

For any questions call: KanCare Clearinghouse, 1-800-792-4884