Kansas Department of Health and Environment

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

KanCare

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