KanCare Ombudsman

Request for Medicaid Hearing

Eligibility, KanCare Health Plan, Fee-for-Service Hearing – Applicant/Beneficiary
Kansas Office of Administrative Hearings

Date: _____

I am requesting a hearing before an impartial hearing officer regarding my Medicaid eligibility or Medicaid services or benefits. I understand I may represent myself or use legal counsel, a relative, a friend, or other spokesperson.

All KanCare Health Plan beneficiaries must complete the appeal process if the adverse decision was made by Amerigroup, Sunflower, or United HealthCare before requesting a fair hearing.

Name of the applicant/beneficiary**:** _____

Case no. _____

Address: _____

Date of Birth: _____

Representative (if applicable): _____

Representative's Address: _____

Representatives should include their authorized representative form when submitting this form to the Office of Administrative Hearings.

Representative is (circle one): a parent or relative, an advocate or friend, an attorney, a health care provider, a guardian, a conservator or other (please specify): _____

I request an Administrative hearing to review the decision or action taken by:

State Agency (KDADS, KDHE): _____

List KanCare Health Plan: _____

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.

_____

_____

_____

_____

(Continue on attached page if necessary)

_____
Name of Person Requesting Administrative Hearing

_____
Name of Person Completing This Form

Submitted Verbally ___ Written ___