Kansas
Department of Health and Environment
Division of Health Care Finance

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

Beneficiary/Patient Spenddown Billed Form

Name: _____

Address: _____

City: _____ State: _____ Zip _____

Instructions for meeting your spenddown:

- ► Each time you get a medical service or item, show your medical card.
- ► Ask your medical provider to bill all the services to your medical card so that they may be applied to your spenddown. Services that are billed by the provider will be automatically applied to your spenddown.
- ► You will receive a summary notice when expenses have been applied to your spenddown through provider billing.
- ► If your medical provider is not a Medicaid provider or cannot bill Medicaid for the service, use this form to document the medical bill.
- ► Ask your provider to complete this form as proof of the medical bill so it may be applied to your spenddown.
- ► When the form is completed, sign it and send it to the KanCare Clearinghouse.
- ► Please use one form per provider. You may request more forms by calling the KanCare Clearinghouse at 1-800-792-4884.

I have received the above listed services and wish that these expenses be considered toward meeting my spenddown.

_____ _____

Signature of Consumer or Responsible Party *Date*

Provider Instructions:

► If you are a Medicaid provider bill Medicaid for all services provided using the Medicaid ID number. The expense can then be applied toward the consumer's spenddown.

► If you are not a Medicaid provider **or** you cannot bill Medicaid for the service, complete the form below so these expenses can be applied toward the spenddown.

Claims provided for: _____ **Beneficiary ID#** : _____

Medical Service Provider Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

	Date of Service (include to and from dates, if applicable)	Service Description	Procedure Code		TPL (yes or no)	Total Charge
			Code Type (circle type)	Enter code and any modifiers		
Ex.	***10/1/03***	***Office Visit***	**HCPCS CPT ADA REVENUE NDC**	***A1234 76,23***	***Yes***	***$40.00***
1.			**HCPCS CPT ADA REVENUE NDC**			
2.			**HCPCS CPT ADA REVENUE NDC**			
3.			**HCPCS CPT ADA REVENUE NDC**			
4			**HCPCS CPT ADA REVENUE NDC**			
5.			**HCPCS CPT ADA REVENUE NDC**			

Name, address and phone number of **person** completing form:

Name (please print): _____

Address: _____

Phone: _____

Signature or Stamp: _____