Kansas Department of Health and Environment

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KanCare

Medical Representative Authorization Form

Consumer Name: _____

Consumer ID or SSN: _____

You can name a person to help you with your medical assistance case. This form is used to appoint a Medical Representative.

A Medical Representative This will be a person who can apply for you, talk about your case with KanCare, send in papers requested, and use your medical card for you. They will get copies of letters about your case. They have to send in your review each year and tell us about changes in your situation. Your Medical Representative can ask for a Fair Hearing or an appeal for you. They can also go with you to a hearing or represent you at the hearing.

You can name a relative, neighbor, friend, or other person you trust to do this for you. They cannot be someone who is trying to collect a medical debt against you.

This person will remain your medical representative until you tell us to remove them.

First and Last Name					
Address Line 1					
Address Line 2					
City		State		Zip Code	
Phone Number		Email Address			
What is this person's relationship to you? (for example: child, friend, neighbor, etc.)					

I authorize the use or disclosure of my health information by the person named above to KDHE DHCF, DCF, and KDADS.
I understand that I have the right to revoke this authorization at any time by notifying KDHE DHCF.
I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.
I understand that I am entitled to a copy of this authorization.
I understand that this authorization will continue until I either revoke this authorization or appoint a different person to serve as my Medical Representative.

My signature on this form signifies that I have read and understand the conditions above.

Signature: _____ Date: _____

Witness signatures are required if the signature above is made with a mark.

Witness: _____ Date: _____

Witness: _____ Date: _____