**Today’s Date:** Click or tap to enter a date.

**I am requesting a hearing before an impartial hearing officer regarding my eligibility, including HCBS waiver eligibility, or Fee-For-Service medical services. I understand I may represent myself or use an attorney, relative, friend or other spokesperson.**

|  |  |
| --- | --- |
| **Applicant/Beneficiary:** Click or tap here to enter text. | **Phone:** Click or tap here to enter text. |
| **Case Number:** Click or tap here to enter text. | **Date of Birth:** Click or tap to enter a date. |
| **Full Address:** Click or tap here to enter text. |
| **Representative (if applicable):** Click or tap here to enter text. | **Phone:** Click or tap here to enter text. |
| **Representative’s Full Address:** Click or tap here to enter text. |

**\*Representatives should include their authorized representative form with this form.**

**Representative is (Check One):**

[ ]  parent/relative; [ ]  advocate/friend; [ ]  attorney; [ ]  provider; [ ]  guardian; [ ]  conservator;

[ ]  other (describe): Click or tap here to enter text.

**Date of Action Being Appealed:** Click or tap to enter a date.

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.

**Click or tap here to enter text.**

You can ask for an expedited (fast) hearing if you have an urgent medical need. **You must send medical documents as proof of the urgent medical need at the time you ask for a fast hearing.** We will review these requests as quickly as possible.We will approve or deny the request based on the documents submitted at the time of the request. If we approve the request, your hearing will be scheduled as quickly as possible. If we deny the request, your hearing will be scheduled in the usual amount of time.

[ ]  I would like to request a fast hearing. **I am sending medical documents**

 **that prove I have an urgent medical need for a fast hearing.**

|  |  |
| --- | --- |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Name of Person Requesting Administrative Hearing | Name of Person Completing This Form |
|  |  [ ]  Submitted Verbally [ ]  Written |

**You may submit your hearing request by mail, fax, or by telephone:**

**Mail:** Office of Administrative Hearings

 1020 S. Kansas Ave.

 Topeka, Kansas 66612

**Fax:** Office of Administrative Hearings 1-785-296-4848

 (Keep a copy of the page that shows your fax was successful.)

**Telephone:** KanCare Clearinghouse (Eligibility decisions) 1-800-792-4884

 KMAP Customer Service (Fee-for-service beneficiary service decisions) 1-800-766-9012

This hearing request form can be found at <https://www.kancare.ks.gov/consumers/appeals-hearings-grievances>