



Medical Review of Emergency Services For Establishing SOBRA Eligibility

I. REQUEST FOR INFORMATION (to be completed by KanCare staff)

Individual's Name: _____
(First) (Middle) (Last)
Birthdate: _____ Case Number: _____ Medicaid ID #: _____

The above-named person has applied for medical assistance from the Kansas Department of Health and Environment, Division of Healthcare Finance. Information is needed to determine **if the medical services provided were for an emergency medical condition** after the sudden onset of a medical condition manifested by symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

KanCare Eligibility Staff: _____ Phone Number: _____
Office Location: _____
Address: _____ City, State, Zip: _____

II. VERIFICATION OF EMERGENCY SERVICES (to be completed by provider)

In order to verify the emergent nature of the services, the following information must be provided, this form attached to those records and the entire document mailed to: Kansas Medical Assistance Program, Office of the Fiscal Agent, CC:765L, SOBRA Staff, P.O. Box 3571, Topeka, KS 66601-3571. This form is not required for labor and delivery services.

To ensure timely processing this form and all documents must be submitted to the fiscal agent within 30 days from receipt of this form.

Payment for services may not be made without the following documentation:

- | | |
|---|--|
| A. For Hospital Services (Inpatient, Outpatient, ER) | B. For All other Outpatient Services (i.e., Physician, FQHC, RHC, etc.) |
| 1. History | 1. Exam Notes |
| 2. Physical | 2. History |
| 3. Admissions & Discharge Summary | |
| 4. Emergency Room Records with Doctor's Exam and Notes | |

Services meeting the above criteria were rendered on the following date(s) _____ through _____
Provider Name: _____ Provider Phone Number: _____

Provider's Signature (or Designee) _____ Address _____ Date Form Completed _____

III. MEDICAL REVIEW (to be completed by SOBRA Manager or Fiscal Agent Staff)

Decision: _____

Authorized Reviewer's Signature _____ Date _____

INSTRUCTIONS FOR MS-2156

Part I must be completed by the KanCare staff and forwarded to the appropriate provider for form completion and records request.

Part II must be completed by the appropriate provider, signed, and attached to the records described within the section, then mailed to:

Kansas Medical Assistance Program
Office of the Fiscal Agent, CC: 765L
Attn: SOBRA staff
P.O. Box 3571
Topeka, KS 66601-3571

Part III must be completed by SOBRA Manager or designated Fiscal Agent Staff and returned to the KanCare Clearinghouse for eligibility finalization.