Division of Health Care Finance
Landon State Office Building
900 SW Jackson, Suite 900 N
Topeka, Kansas 66612-1220

Phone: 785-296-3981
Fax: 785-296-4813
www.kdheks.gov

Susan Mosier, MD, Secretary

Department of Health & Environment

Sam Brownback, Governor

Medical Representative Authorization Form

You can name a person to help you fill out the medical assistance application. This person will also be able to sign your application, answer questions for you, and use your medical assistance card for you. We will share information with this person. This person will get copies of letters sent to you about your case. This person is responsible for completing your review each year and for telling us about changes in your situation. The Medical Representative can be a relative, neighbor, friend, or other person you trust. You may not name someone who is trying to collect a medical debt against you.

If you want to have someone act in your behalf, complete the information about this person below:

First Name: _____ Last Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ ZIP Code: _____

Telephone Number: _____ Email Address: _____

What is this person's relationship to you (for example: Child, Friend, Neighbor, etc.)? _____

I appoint the above named person to be my Medical Representative to apply for and manage my health insurance. This person will receive copies of any letter sent about my case and will be responsible for completing review forms, providing information and reporting changes on my behalf:

Signature: _____ Date: _____

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

Witness: _____ Date:_____

Witness: _____ Date:_____

Please send this completed form to the office where the application was submitted.