Kansas Office of Administrative Hearings

Medicaid Provider - Administrative Hearing Request

Complete this form ONLY if you are a provider (not a Medicaid recipient or applicant) and want to request an administrative hearing of a decision made by the KanCare Program.

You may submit this form online by filling it out completely and clicking on the “Submit” button at the end of the form.

Today’s Date*

Provider Information

Provider Name*

Provider ID Number

Provider Representative Information

First Name*

Last Name*

Mailing Address *

Street Address

Address Line 2

City

State / Province / Region

Postal / Zip Code

Country

Phone Number*

Ext. #

Fax Number

Email Address

Patient Information

Patient First Name*

Patient Last Name*

Additional Information

What type of Decision are you appealing*

Date of the Notice you are appealing*

Who is the notice from*

Reason(s) for your request. I am requesting consideration of this matter BECAUSE:*

Are you appealing as A provider? ◯ Yes ◯ No

Are you a provider Appealing as a Representative of the Patient? ◯ Yes ◯ No

Signature*

Type your name

* Indicates a required field