Kansas Office of Administrative Hearings

Medicaid Recipient - Administrative Hearing Request

Complete this form ONLY if you want to request an administrative hearing of a decision made on a Medicaid case or a Medicaid application.

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*

Information about Medicaid Applicant or Recipient

First Name*

Last Name*

Mailing Address*

Street Address

Address Line 2

City

State / Province / Region

Postal / Zip Code

Country

Phone Number

Fax Number

Email Address

Representative / Attorney

Name address, and telephone number of your Representative or Attorney, if you have one. Attorney representation Is NOT REQUIRED. We will send information on your case to your representative or attorney if you complete this section.

First Name

Last Name

Mailing Address

Street Address

Address Line 2

City

State / Province / Region

Postal / Zip Code

Country

Phone Number

Fax Number

Email Address

Information about Notice or Action appealing

Date of the Notice
you are appealing*

Worker / Employee /
Agent*

Agency Office*

Type of Program

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

Are you receiving
Benefits / services? ◯ Yes ◯ No

End of benefit /
service date

If you have an emergency health issue, you can ask for a faster (expedited) hearing. If you request an expedited administrative hearing, you may be contacted by the Kansas Medicaid Program to provide proof of your emergency health issue.

Would you like an
Expedited fair hearing ◯ Yes ◯ No

Name of Person Completing this Form

First Name*

Last Name*

Your relationship to the Medicaid Applicant or Recipient*

Signature*

Type your name

* Indicates a required field