



www.kansashealthsolutions.org

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CREDENTIALING/SPECIALTY COB FORM

The intent of this form is to establish verification of no other coordination of benefits for the patient on the attached claim. The billing provider is required to submit this form with each claim that meets eligibility criteria, as outlined in Provider Notice 2.3 dated October 1, 2008, section #2:

“Provider license type is not recognized by Primary Insurer, but is a provider type covered by the Prepaid Ambulatory Health Plan program.”

The rendering provider of service is not covered/contracted by the patient's primary insurance for the billed service, and billing provider is not able to bill in order to receive denial from the primary insurance.

PROVIDER:

PROVIDER SPECIALTY:

Signature

Date

1. Complete ALL sections of this form. Information provided must be either typed or printed legibly.
2. Providers will submit forms to Kansas Health Solutions via first class US mail with a red 1500 claim form.
Mail to: KHS
Provider Services
P.O. Box 1979
Topeka, KS 66603
3. For questions about this form, contact provider services at: 1-866-547-6457