

Kansas Health Solutions 1915(b) Services Authorization

Instructions: Complete prior to provision of 1915(b) Services (i.e., Attendant Care and Case Conference) for which claims will be submitted to KHS.

Member Name: _____	Date of Birth: _____
Last First Middle	mm/dd/yy
Medicaid Number: _____	Social Security Number: _____

COMPLETE IF PROVIDER IS PART OF AN AGENCY OR GROUP PRACTICE

Provider Agency: _____

COMPLETE IF PROVIDER IS IN INDEPENDENT PRACTICE (I.E., NOT PART OF AN AGENCY OR GROUP PRACTICE)

Provider Name: _____

Last First Middle

For prior authorized services to be approved, member must have an active Outpatient Mental Health Registration completed by the provider.

Primary Diagnosis:

Indicate Axis Number	Code	Description

Additional diagnostic information will be obtained from the Outpatient Mental Health Registration.

Check the box corresponding to the 1915(b) service(s) being requested.

Service(s)	Units Requested
<input type="checkbox"/> 1915(b) Attendant Care (Up to 1000 units)	
<input type="checkbox"/> 1915(b) Case Conference (Up to 16 units)	

Timeframe of Request: Start Date: _____ (mm/dd/yy) End Date: _____ (mm/dd/yy)

Maximum end date – June 30th of benefit year

ATTENDANT CARE ONLY SECTION – Complete if Attendant Care is being requested.

Has SED Waiver eligibility been assessed (if member is an adult, check Not Applicable)?

Yes No Not Applicable

Provide in detail why Attendant Care is medically necessary: _____

Rationale for the medical necessity of Attendant Care must be substantiated within progress note documentation.

Completed By: _____ Date: _____ (mm/dd/yy)

First Name Last Name

Contact Number: _____