PLEASE PRINT PLEASE PRINT PLEASE PRINT

Kansas Health Solutions

Exception Request for Services Which Exceed the Limits of Initial Authorization

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

Check the box corresponding to the service for which the initial authorization limits have been met.

Service	Units Requested	Service	Units Requested
☐ Admission Evaluation		☐ Psychological Testing	
☐ Individual Therapy		☐ Group Psychosocial Rehabilitation/ Group Peer Support	
☐ Family Therapy		☐ Other_____	
☐ Group Therapy			

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

Provide in detail the reason for this request (i.e., why are additional units medically necessary?):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Completed By: _____ Date: _____ (mm/dd/yy)
First Name Last Name

Contact Number: _____

Phone: 1-877-642-9283
Fax: 1-785-232-2610