Date: _______________  
I am a provider requesting a hearing before an impartial hearing officer to review the reimbursement decision for services rendered to a managed care beneficiary or a fee-for-service beneficiary. I understand I may represent myself or use an attorney, relative, friend or other spokesperson.

Provider Name: _____________________________________ Phone: ____________________________  
Beneficiary Name: ____________________________________

Representative (if applicable): ____________________________ Phone: ____________________________  
Representative’s Address: ____________________________________________

Providers may request an administrative hearing for a reimbursement dispute using this form. Providers may represent a Medicaid beneficiary for all other disputes. If you are a provider representing a Medicaid beneficiary, please use the Applicant/Beneficiary Hearing form. Please include your authorized representative form when submitting the hearing request form to the Office of Administrative Hearings.

If the reimbursement dispute involves an adverse decision by Aetna, Sunflower or United HealthCare, providers may request a reconsideration and/or an appeal. Providers must complete the appeal process with Aetna, Sunflower, or United before requesting a fair hearing. Fee-for-Service providers may request a fair hearing immediately after receipt of the adverse reimbursement decision notice.

I request an Administrative hearing to review the decision or action taken by:  
State Agency (KDADS, KDHE): ________________________ List KanCare Health Plan: ________________________

Date of Action Being Appealed: ____________________________

Please attach a copy of the notice about which you are appealing. Explain why you are not satisfied with the decision and send copies of any documents you think may help explain the problem.

____________________________________________________

____________________________________________________

____________________________________________________

(Continue on attached page if necessary)

Name of Person Requesting Administrative Hearing  Name of Person Completing This Form  
Submitted Verbally _______ Written _______

You may submit your Provider fair hearing request by mail or fax:  
Mail: Office of Administrative Hearings  
1020 S. Kansas Ave.  
Topeka, Kansas 66612

Fax: Office of Administrative ___________ 1-785-296-4848  
(Keep a copy of the page that shows your fax was successful.)

Phone: Aetna ______________________ 1-855-221-5656  
Sunflower ________________________ 1-877-644-4623  
United ________________________ 1-800-542-9238  
KMAP Customer Service ____________ 1-800-933-6593

This hearing request form can be found at www.oah.ks.gov/Home/Forms