Kansas Medical Assistance Program
PA Phone 800-933-6593
PA Fax 800-913-2229

Aetna Better Health of KS
PA Medical Phone 855-221-5656
PA Medical Fax 855-225-4102
PA Pharmacy Phone 855-221-5656
PA Pharmacy Fax 844-807-8453

Sunflower
PA Medical Phone 877-644-4623
PA Medical Fax 888-453-4316
PA Pharmacy Phone 877-397-9526
PA Pharmacy Fax 833-645-2740

United Healthcare
PA Medical Phone 866-604-3267
UHCprovider.com
PA Pharmacy Phone 800-310-6826
PA Pharmacy Fax 866-940-7328

All fields may not be appropriate or necessary for all requests. Please submit information based on EPSDT considerations reflected in the form that, in your judgment may be pertinent/helpful for the specific case in aiding a determination of medical necessity.

EPSDT Medical Necessity Form

Non-Covered State Medicaid Plan Services Request Form for Recipients *Under* 21 Years Old

1. **Recipient information**: This must be completed by a physician, licensed clinician or other provider.
   NAME: _____
   DATE OF BIRTH: _____(mm/dd/yyyy) MEDICAID ID NUMBER: _____
   ADDRESS: _____
   _____
   _____
   _____
   _____

2. **Medical Necessity**: All requested information, including CPT and HCPCS codes if applicable, as well as provider information, must be complete. Please submit records that support medical necessity.

   REQUESTOR NAME: _____ PROVIDER NAME: _____
   NPI: _____ NPI: _____
   ADDRESS: _____ ADDRESS: _____
   _____ _____
   _____ _____
   _____ _____
   _____ _____
   TELEPHONE: _____ TELEPHONE: _____
   FAX: _____ FAX: _____

   REQUESTED PROCEDURE, PRODUCT OR SERVICE: _____

   CPT/HCPCS CODE: _____ /_____

3. **In what capacity have you treated the recipient?** (Include how long you have cared for the recipient and the nature of the care.)
   _____
   _____
   _____
   _____

4. **What is the recipient's health history?** (Include chronic illness.)
   _____
   _____
   _____
   _____
   _____

5. **What is/are the recent diagnosis(es) related to this request?** (Include the onset and course of the disease and the recipient's current status.)
   _____
   _____
   _____

6. **What treatment has been given for the diagnosis(es) above?** (Include previous and current treatment regimens, duration, treatment goals and the recipient's response to treatment(s).)

_____
_____
_____

7. **Please provide a description of how the requested procedure, product or service will correct or ameliorate the recipient's defect, physical or mental illness, or condition (the problem).** (**Must** include a detailed discussion about how the service, product or procedure will improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening or prevent the development of additional health problems.)

_____
_____
_____
_____
_____
_____
_____

8. **Is this request for an experimental or investigational treatment?**
   _____YES _____NO
9. **Is the requested product, service or procedure considered to be safe?***
   _____YES _____NO
10. **Is the requested product, service or procedure effective?***
    _____YES _____NO
11. **Are there alternatives to the product, service or procedure requested that would be more cost effective but similarly medically effective?**
    _____YES _____NO
    If yes, specify what alternatives are appropriate for the recipient and provide evidence base with this request, if available.

_____
_____
_____
_____

12. **What is the expected duration of treatment?**

_____
_____
_____
_____

_____ _____

REQUESTOR'S SIGNATURE & CREDENTIALS **DATE**

*Kan. Admin. Regs. § 30-5-58 (ooo)

(2) "Effective" means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects."
(4) The scientific evidence for each existing intervention shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Coverage of existing interventions shall not be denied solely on the basis that there is an absence of conclusive scientific evidence. Existing interventions may be deemed to meet this regulation's definition of medical necessity in the absence of scientific evidence if there is a strong consensus of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of those standards, convincing expert opinion.